

**CASE STUDIES OF INTER-DISCIPLINARY TEAM
PRACTICES FOR CHILDREN WITH HIGH AND
COMPLEX NEEDS IN AOTEAROA NEW ZEALAND**

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CONTENTS

| | PAGE |
|---|------|
| TITLE PAGE | 1 |
| ACKNOWLEDGEMENTS | |
| LIST OF CONTENTS | |
| ABSTRACT | 2 |
| CHAPTER 1 INTRODUCTION | 3 |
| The historical development of multidisciplinary team | 3 |
| Team models and definitions | 5 |
| The New Zealand High and Complex Needs Unit (HCN) | 6 |
| Importance of research on multidisciplinary team process | 8 |
| CHAPTER 2 LITERATURE REVIEW | 10 |
| Research on Multidisciplinary Teams in Special Education | 11 |
| Research on Multidisciplinary Teams in Early Intervention (EI) | 15 |
| Research on Multidisciplinary Teams in Children's Mental Health | 19 |
| Research on Multidisciplinary Teams Using Independent Observers | 22 |
| Research on Multidisciplinary Teams in New Zealand | 33 |
| The New Zealand HCN Process | 37 |
| Summary | 39 |
| CHAPTER 3 METHOD | 45 |
| Research Design | 45 |
| Recruitment | 45 |
| Participants | 46 |
| Procedures | 47 |
| Instrumentation | 47 |

| | |
|---|-----------|
| CHAPTER 4 RESULTS | 51 |
| Interviews | 51 |
| Observations of meetings | 69 |
| Team “Sam” | 69 |
| Team “Chris” | 74 |
| Team “Alex” | 79 |
| CHAPTER 5 DISCUSSION | 87 |
| Interpretation | 87 |
| Conclusions | 92 |
| Strengths | 93 |
| Limitations | 93 |
| Implications for Practice | 94 |
| Implications for Future Research | 95 |
| REFERENCES | 96 |
| APPENDICES | |
| 1. Letter of Approval from the Human Ethics Committee | 102 |
| 2. Information Sheet | 104 |
| 3. Consent Form (blank) | 107 |
| 4. Interview Questions | 109 |
| 5. Meeting Observation Form | 123 |
| 6. Compiled Interview Responses | 125 |
| 7. Rating Individual Participation in Teams Scale (Bailey & Helsel-DeWert, 1981) | 147 |
| 8. Information on the High and Complex Needs Unit | 153 |

LIST OF TABLES

| | |
|--|----|
| Table 1 Summary of Facilitators and Barriers Identified in the Literature | 40 |
| Table 2 Descriptions of Instrument | 49 |
| Table 3 Summary of Individual Responses | 63 |
| Table 4 Team “Sam”: Percentage of Total Activities Observed for Meeting 1 and Meeting 2 | 71 |
| Table 5 Team “Chris”: Percentage of Total Activities Observed for Meeting 1 and Meeting 2 | 76 |
| Table 6 Team “Alex”: Percentage of Total Activities Observed for Meeting 1 and Meeting 2 | 81 |
| Table 7 Average Number of Observed Team-Related Behaviours | 85 |
| Table 8 Average Proportion of Time Spent on Aspects of Team Process during Meetings | 86 |

LIST OF FIGURES

| | |
|--|----|
| Figure 1. Team “Sam”: changes of percentages from meeting 1 and meeting 2 | 72 |
| Figure 2. Team Sam: percentage time spent on positive meeting behaviours, negative meeting behaviours and others | 73 |
| Figure 3. Team “Chris”: changes of percentages from meeting 1 and meeting 2 | 77 |
| Figure 4. Team Chris: percentage time spent on positive meeting behaviours, negative meeting behaviours and others..... | 78 |
| Figure 5. Team “Alex”: changes of percentages from meeting 1 and meeting 2 | 82 |
| Figure 6. Team Alex: Percentage time spent on positive meeting behaviours, negative meeting behaviours and others..... | 83 |

Abstract

The use of multidisciplinary team approach has become one of the preferred service deliveries to help children and young people with high and complex needs. However, there has been little empirical research in this area, particularly within the New Zealand context. Further, a common problem in the existing studies is the use of subjective rating scales or self reports to collect data. Therefore the aim of this study is to describe the team processes of three intersectoral teams in the New Zealand High and Complex Needs Unit using objective data collection method, as well as exploring particular issues associated with the three teams. Valid instruments were developed in order to record the meeting behaviour as frequency tally and the participants were interviewed to seek their views on the issues associated with their team. The results suggested that the teams engaged in positive team behaviour 82% to 93% of the meeting duration and negative meeting behaviour were observed during 2% to 5% of the meeting times. Further, the teams spent just under half of the meeting time in proposing and discussing goals and strategies. The teams were able to reach decisions and distributed responsibilities in less than 6 minutes. More than half of the participants had positive attitudes towards collaborative work and considered the team meetings as an effective mechanism for problem-solving and plan evaluation. The facilitators and the barriers identified in this study are consistent with the literature. Implications for future practice and research are discussed.

Chapter 1

Introduction

Children and young people under the age of 18 make up nearly a quarter of the total population in New Zealand. Last year the New Zealand Government spent over \$70 millions on improving the outcomes of children and young people in this country. However, helping children and young people is not a simple task. The environment in which the children and young people live has a significant impact on their development and behaviour. When a child or a young person has needs in one area, the intervention often requires changes in other areas as well. Sometimes the needs of a child or a young person can be so complex that a variety of skills is required in order to address all aspects of their needs. This gives rise to the use of a multidisciplinary team approach as one of the primary strategies to help children and young people with high and complex needs.

The historical development of multidisciplinary teams

The practice of a multidisciplinary team approach can be traced back to the early 1990s as training of doctors in medical specialities began to develop (Heinemann, 2002). As a result of increasing specialisation, there was a need for physicians to work together in order to communicate information about shared patients, as well as to coordinate the specialists' skills. However, it is only since the second half of the 20th century that the use of multidisciplinary teams has gained attention and popularity in the human services field (Ogletree, Bull, Drew, & Lunnen, 2001). This shift towards multidisciplinary team assessment and intervention may be attributed to a number of reasons. The increasing popularity of the ecological

conceptualisation of child development (Bronfenbrenner, 1992) has resulted in many professionals recognising the multi-system effect on the children and the families they serve: learning does not occur in isolation and skills are developed as a result of interactions between the child and its environment. Therefore the needs of the children are often interrelated which requires multisystemic interventions on the part of the professionals (Pearson, 1982; Forney, 2004). For instance, approximately one third of children with specific learning disabilities have the comorbid condition of Attention Deficit Hyperactive Disorder and are at higher risk of developing social skills impairment and emotional and behavioural disorders such as depression and conduct disorders (Batshaw, 2002). In addition, because of the breaking down of traditional family models and ever-changing technologies, professionals have found themselves serving a population with increasingly complex problems as compared with 30 years ago (Keys, Bemak, Carpenter & King-Sears, 1998): there are more sophisticated and organised youth crimes, heavier and more accessible party pills, multiple living arrangements for children with separated parents, and the increasing number of teen internet millionaires, just to name a few problems. The team approach has become the preferred service delivery as a result of mounting public criticism of uncoordinated services, lack of qualified staff and shortage of funding (Billups 1987; Heinemann, 2002; Hansen, Litzelman, Marsh & Milspaw, 2004). Reports such as Knitszer's *Unclaimed Children* (1982, cited in Litzelman, Marsh & Milspaw, 2004) and the President's New Freedom Commission's report (2003, cited in Litzelman, Marsh & Milspaw, 2004) have also led to government legislation in the United States of America to mandate the use of multidisciplinary team and multi-system collaboration. Major reform efforts in the area of children's services at the state level have also been made in North America, Britain, Europe, Australia and New Zealand

in order to provide more effective and integrated services to improve outcomes for children and families in need (Rosenblatt, 1996; Anderson & McIntyre, 2002; Farmakopoulou, 2002; Ramage, Bir, Towns, Vague, Cargo & Niumata-Faleafa, 2005).

Team models and definitions

Current theories point to three distinctive team models: multidisciplinary, interdisciplinary and transdisciplinary (Ogletree, Bull, Dew & Lunnen, 2001). Each model places different emphasis on patterns of communication, leadership style, the role of the family and discipline boundaries. In the literature, however, the terms “multidisciplinary”, “interdisciplinary”, and “interprofessional” are often used interchangeably and will be used as such in this study. A multidisciplinary team (MDT) is used throughout this study to refer to the multiplicity of members’ training. Pfeiffer (1980) defined an interprofessional team as “an organised group of personnel each trained in different professional disciplines and possessing unique skills and perspectives, who share a common purpose of cooperative problem solving” (p. 389). Øvretveit (1993) provided another definition of a multidisciplinary team as “a group of practitioners with different professional training (multidisciplinary), employed by more than one agency (multiagency), who meet regularly to coordinate their work providing services to one or more clients in a defined area” (cited in Farmakopoulou, 2002, p.1055). An intersectoral team (IST), however, emphasises on the services provided by members in their respective sectors. For instance, an IST may consist of professionals from different sectors such as education, mental health or justice. As members of the IST are representatives of the service sectors, it is most likely multidisciplinary in nature.

Another similarly broad but important concept is team process. Team process, or team functioning is what team does in carrying out the agreed tasks in order to achieve their common goals (Nichols, DeFries & Malone, 2002). Billups (1987) provided a detailed description of a team process as including “both what a team does (its rationale, task oriented, or goal achievement functions) and how it goes about doing it (its socio-emotional maintenance orientated or self renewing functions) (p.147)”. Collaboration is another term which is used in the literature to describe team process as Armitage (cited in Farmakopoulou, 2002, p.1051) defined it as “the exchange of information between individuals which has the potential for action in the interests of a common purpose”.

The New Zealand High and Complex Needs Unit (HCN)

The High and Complex Needs Unit (HCN), established in 2001, is a joint intersectoral case management strategy of the Ministry of Health (MoH), Ministry of Education (MoE) and the Department of Child, Youth and Family Services (CYFS) of the Ministry of Social Development (www.hcn.govt.nz). As children with high and complex problems often have needs overlapping services provided by the three sectors (CYFS, MoE & MoH), an integrated service delivery is necessary to provide holistic care for these children and young people. The HCN is the most recent government initiatives to provide a high level of expertise and pooled funding from the three sectors for intensive interventions for children and adolescents with the highest and most complex needs and who typically have made no progress for a long time. The funding is limited to 100 children or adolescents up to 21 years of age nationally per year. HCN provides additional services without replacing existing

available services. The focus is on providing high quality intervention to bring about rapid changes within a short period of time.

CYFS provides a wide range of social services, with a focus on children, young people and families in need of support (www.cyf.govt.nz). The two main services offered are care and protection of children, and youth justice. Each year CYFS receives more than 25,000 cases of suspected child neglect and abuse. More than 7600 children and young people nationwide are placed in alternative care including residences, family homes and foster homes. Youth justice deals with more than 7500 young offenders every year who are between the ages of 14 and 16. The aim is for them to be accountable for their actions and to reduce the risk of re-offending.

Group Special Education, also known as GSE, is part of the Ministry of Education which aims to improve educational opportunities and outcomes for children and young people with special education needs. There is no separate special education system in New Zealand as laid down by the 1989 Education Act for equal rights to state school education for all students. Under the resourcing scheme of Special Education 2000 (SE 2000) policy, 3 % of school aged children with the highest needs receive Ongoing and Reviewable Resourcing Schemes (ORRS) funding to help them to access the curriculum. Funding is available also for 4% - 6% of school aged children with moderate learning needs and 5% of children aged 0 to 5 (Ministry of Education, 2005).

Child and Adolescent Mental Health Services (CAMHS) of Ministry of Health receive referrals from health professionals to provide services to children young people and their families who experience mental health difficulties. The prevalence of mental health disorders amongst children and young people in New Zealand was

estimated to be about 18% for 11 years old (Fergusson, Horwood & Lynskey, 1997). Approximately 25% of the young people aged 15 meet the DSM criteria of mental health disorders and 42% at age 18 years old (Fergusson & Horwood, 2001). However, only 2.07% of the 10-14 age group accessed mental health services and 3.10% for the 15-19 age group (Ramage et al., 2005). These statistics suggest that there are discrepancies between the children and young people in need of mental health services and those who access them.

Importance of research on multidisciplinary team process

Team process, as defined previously as what the team does in order to achieve its common goal, is of important interest to researchers because it is shown to be related to team performance (Brannick, 1995). To better understand the relationship between team process and team performance, Polivka (1995) presented a model of team process in which consisted of five major constructs: environmental factors, situational factors, task characteristics, interagency processes and outcomes. Brannick's (1995) analogy of the sailboat race illustrates vividly the relationships between these variables. To finish the race in time (outcome) depends partly on the weather (environmental factors), partly on the design of the boat (situational factors), the level of difficulty of the sailing route (task characteristics) and team coordination (interagency process). Although team process has been researched over 50 years most of the literature remains theoretical in nature. The existing literature of empirical studies is relatively sparse and many studies used retrospective self report rather than objective observations. This is particularly true within the New Zealand context. As this subject has not been adequately researched, objective detailed empirical research is necessary. Therefore the purpose of this study is to describe the team process of

three intersectoral teams that come together to develop intervention plans for children with high and complex needs. It is hoped that the information from this study will contribute to our understanding of the intersectoral team practices and stimulate further research interest; and ultimately promote quality of service delivery to children, young people and their families in New Zealand.

Chapter 2

Literature review

The purpose of the literature review is to describe the research on multidisciplinary team processes in the related fields of child and adolescent. In particular this chapter aims to identify and summarise the empirical studies in the literature. Literature was found from a number of sources: the Internet, the university library, references listed in the bibliographies of secondary sources, relevant New Zealand Government Ministry websites and computer databases of PsychInfo and ERIC. The date range of the databases was set from the earliest to 2005. The search terms used were as follows: 'team process returned' 47 results; 'team meeting' returned 16 results; 'interagency' and 'collaboration' returned 27 results; empirical literature review on 'team' returned 23 results; and empirical literature review on 'team process' returned 3 results. The articles included in this chapter were selected using the following criteria:

- Empirical journals in which the study design involve actual observation or experiment.
- Research involving MDT. This means that teams must include members from more than two disciplinary training backgrounds.
- Research involving teams who work in the field related to children and adolescents, for instance, education, mental health, social welfare or the juvenile court.
- Research which focuses on the team process.

A total of 21 articles were identified and are reviewed in the following order:

MDT in special education, MDT in early intervention, MDT in children's mental health, MDT research using a direct observation method and MDT in New Zealand.

Research on multidisciplinary teams in special education

School-based multidisciplinary teams provide services to students with special education needs in order to help them to access the curriculum and to maximise their learning potential. The planned services may include assessment, consultation, development of Individual Education plans (IEPs), implementation of IEP, evaluation, and coordination of resources between schools, parents and communities. In 1975, United States Public Law 94-142 Education of All Handicapped Children Act (now known through legal revision as IDEA , Individuals with Disabilities Education Act) mandated that the assessment and decisions about the educational placement were to be made by a multidisciplinary team (Payne, no date). The rationale behind the team approach was to facilitate clinical judgement from a group of specialists in order to reduce errors in individual bias. The passage of the law sparked research interest in school-based multidisciplinary teams and a number of important empirical studies were carried out in the next decade.

Pfeiffer (1981) surveyed 147 members serving on 40 school-based special education teams about their perceptions regarding problems facing their teams. The teams were typically composed of school psychologist, special educator, school social worker and related support personnel. The typical meeting length was ½ hour to 1 hour as reported by 79% and 20.4% of the respondents respectively. "Lack of programme options to select from" was perceived as the most problematic area by 83% of the respondents. This was followed by "fiscal restraints" (53%), "lack of

opportunity to follow up” (46%), “lack of time for diagnostic discussion on an individual case (45%), “lack of bilingual staff” (45%) (p.331-332). The results of this study showed that the members perceived that the majority of the problems were contextual factors such as time and money; very few problems identified were directly related to the team process such as “no clear definition of roles” (2%) or “lack of clarity of team purpose” (p. 332). In fact, members generally regarded team processes as problem-free areas.

Pfeiffer (1982) also investigated the effectiveness of team decision-making versus individual decision-making in special education placement. The participants were 102 Puerto Rican educators (classroom teachers and diagnostic specialists) attending a training conference for special education. The participants were given 10 referrals to read and were asked to select independently the most appropriate placement from the 7 placement options available from the Rucker-Gable Educational Placement Scale Continuum of Services (RGEPS): 1. regular classroom 2. consultation 3. consultation & direct services 4. resource room 5. part-time special class 6. full time special class 7. residential programme. The 7 placement options were on a continuum of full integration (option 1) to segregation (option 7). Participants then were randomly divided into a team of three (i.e. total of 34 teams) and this time they were asked to make the placement decision as a team, for the same 10 referrals on the RGEPS. It was found that there was significantly less variability in team decisions (standard deviation= .917) than individual decisions (standard deviation= 1.347). When acting as individuals, participants generated a wider range of placement options than that of the teams. The same individuals however made consistently narrower range of options when they served on teams. For instance, the placement recommendations made by the 34 teams for one of the referrals “Juan”

ranged from regular classroom (option 1) to consultation and direct services (option 3). However, individuals' placement recommendations for "Juan" range from a full spectrum of regular classroom (option 1) to residential treatment (option 7). Since variability is one way to conceptualise error, the result of this study showed that teams were more effective in reducing erroneous judgements on placement decisions than individuals.

The same study was replicated by Pfeiffer and Naglieri (1983) by sampling 86 professionals served on 23 multi-disciplinary teams. Each team consisted of at least one psychologist, one special education teacher, one regular education administrator and may include, in addition, a social worker, special education supervisor, school counsellor, and/or speech-language therapist. Teams had worked together for at least one year with an average of 5.6 years experience in their respective fields. Members were given 2 real referrals to read and were asked individually to determine the most appropriate placement from the 7 options of RGEPS. A week later the teams met together to discuss their decisions and the results were compared to the ratings of 20 special education experts. Pfeiffer and Naglieri (1983) found that in both instances the placement recommendations made by the teams were consistently closer (mean_{referral 1} = 5.00, mean_{referral 2} = 5.05) to that of the experts' (mean_{referral 1} = 5.00, mean_{referral 2} = 5.20) than the individuals' (mean_{referral 1} = 5.08, mean_{referral 2} = 5.44). There was also less variability in the team decisions than members acting independently. For instance, the recommendations made by teams for the first referral ranged from resource room (option 4) to full time special class (option 6), which was not far off from the experts' recommendation of part-time special class (option 5). Individuals, however, had a wider range of recommendations from consultation (option 2) to residential

programme (option 7). The result of this study suggested that professionals had greater accuracy in making placement decisions as a team than as individuals.

Frankerberger and Harper (1988) investigated members' perceived influence of decision-making during multidisciplinary diagnostic assessment meetings. The participants of the study were 235 multidisciplinary team members consisted of psychologists, speech-language pathologists, special education teachers, classroom teachers, reading specialists, guidance counsellors, medical specialists, social workers, parents and others. Members were asked to rate the importance of each member's contribution (including their own) when making diagnostic decisions as a team regarding a child's disability, on a Likert scale of 1(unimportant) to 8 (important). The results showed that overall the team members valued each profession's contributions as all professional categories received mean ratings of 4 and above (rating 4="important"). However, some members were clearly perceived as more influential than others: the five most frequently rated professionals were (in ranking order): psychologists who received the highest number of ratings (229), followed by special education teachers (224), parents (210), classroom teachers (191), and speech pathologists (165). Interestingly, members' importance ratings varied very little as a function of child's suspected condition. For instance, psychologists and the special education teachers were perceived as the two most influential professional members whether the child's suspected conditions were learning disability, mental retardation, or emotional disturbance. When the child's suspected condition was in the area of speech-language delay, guidance counsellor, psychologists and the speech language therapists topped the three most important members.

Huebner and Gould (1991) surveyed 117 school psychologists serving on multidisciplinary teams for special education placement regarding their perceptions

about team functioning. On a five point scale (1=no problem to 5=extreme problem), the respondents indicated “minor” to “moderate problems” in all items including “role clarity” (mean=1.9), “team goals” (mean=1.9), “time to make intervention plan” (mean=3.0), “participation by parents” (mean=2.8), “participation by regular educators” (mean=2.7), “systematic decision-making” (mean=2.4), “interdisciplinary trust/collaboration” (mean=2.1), “appropriate follow-up” (mean=2.8), “attention to parents’ emotional needs” (mean=2.4) (p.432). The respondents also indicated “average” overall satisfaction with their team meetings. Twenty-nine percent of the respondents reported that they received no formal training for MDT leadership whereas 39% of them served as team leaders.

Research on multidisciplinary teams in early intervention (EI)

The use of multidisciplinary teams in the field of early intervention (EI) was initially developed for the care of high risk pre-term infants (Forney, 2004). Today the term “early intervention” typically applies to a population of pre-school children from birth to age five years with developmental concerns such as physical disability, sensory impairments, learning or communication delay, social, emotional or behavioural difficulty. The EI team may plan services including screening assessment for development delay, speech-language therapy, physiotherapy, occupational therapy, behaviour management, education for parents and teachers, strategies to teach new skills or to improve social and learning skills. Members of the team may also deliver the services or arrange resources for services to be delivered. Although early intervention is one aspect of the special education services, the emphasis of early intervention is primarily on enhancing the child’s overall development through mainly play-based therapy rather than teaching a specific curriculum. EI services can be both

remedial and preventive in nature and are not restricted to a school setting. Service provisions may occur in a variety of contexts such as home, hospital and community centres (Thurman, Cornwell, & Gottwald, 1997). Three studies have described the factors that contribute to, or impede, successful team functioning in early intervention.

Lamorey and Ryan (1999) surveyed members' perceptions of factors which contributed to team's effectiveness and ineffectiveness and analysed the results according to three team models: interdisciplinary (ID), multidisciplinary (MD) and transdisciplinary (TD). The participants were 195 EI professionals who were teachers (57%), occupational-, physical- or speech-language therapists (29%), nurses (3%), parent trainers and coordinators/directors (9%). The majority of team members had a Master's degree or higher qualification (86%) and most of them had a minimum of 5 years of field experience. The majority of teams had 4 to 6 members with meeting duration of 30 to 60 minutes. Responses regarding facilitators of team effectiveness were similar across all three teams models which ranged from 19% to 38%: "adequate time on team building and team maintenance", "effective team leadership", "resolution of role, turf, status issues", "effective follow-up services and increased skills across traditional discipline boundaries" (p.316). Responses to factors contributing to team ineffectiveness varied relative to the three team models. The five most rated factors for MD respondents were: "staff overworked" (46%), "lack of administrative support" (35%), "philosophical differences among team members" (29%), "resistance to change" (29%) and "inequitable distribution of workload" (26%) (p.317). The five most rated factors for ID respondents were: "staff overworked" (42%), "resistance to change" (33%), "unclear team philosophy and long term goals" (31%), "lack of training in team building/maintenance" (29%) and "lack of competency among other team members" (28%) (p.317). The five most rated factors

for TD respondents were: “policies/procedure unwritten” (36%), “training background too specific” (34%), “lack of communication caused by specialised terminologies” (30%), “territory and role confusion” (30%), and “lack of administrative competency” (30%) (p.317). The results of this study suggested that members identified common factors which facilitated team effectiveness. However, specific barriers to team effectiveness may be related to how the team were structured.

Polivka, Dresbach, Heimlich and Elliott (2001) surveyed 47 members of the EI teams in rural communities regarding their perceptions about interagency relationships and explored factors which influenced interagency relationships. The members came from a variety of agencies: health care (16.3%), educational services (55.1%), welfare/child services (4.1%), referrals/training (10.2) and others (14.3). Over half of the participants (58.7) were employed in the agencies for over 5 years. The conceptual framework used to study interagency collaboration included five main constructs: “environmental factors” (i.e. political or social policies to foster interagency collaboration efforts) , “situational factors” (i.e. current organisational rules or constraints which contribute to the interagency relationship), “task characteristics” (i.e. skills required to accomplished the joint activities), “interagency processes” (i.e. how information and funds were shared amongst agencies) and “outcomes” (i.e. whether the collaborative goals were achieved and the degree of satisfaction between the agencies) (p.341). On a Likert scale of 1 (=not at all) to 5(=great extent), members’ perceptions were that “state level policies encouraged local interagency collaboration” (mean=3.91), “agree on local lead education needs” (mean=3.74), “knew specific goals and services of the other agencies” (mean=3.56), “know staff at each agency” (mean=3.47), “satisfied with relationship with other agencies” (mean=3.38) and “achieved collaborative goals” (mean=3.21) (p. 345).

Members also indicated that they did not “obtain funding from the same sources” (mean=1.90), “provide same services” (mean=2.20), “coordinate activities with other agencies” (mean=2.60), or consider “other agencies important in helping attain their agency’s goals” (mean=2.70) (p. 345). In addition, 81% of the agencies reported that there was no formal collaborative agreement with each other. Further analysis suggested that situational factors and environmental factors had a direct impact on interagency process (path coefficient=.47 and path coefficient=.25 respectively). Interagency process (path coefficient=.54) and situation factors (path coefficient=.23) in turn had a direct impact on the outcomes.

To further examine the effect of organisational settings on team functioning, Malone and McPherson (2004) surveyed 15 community-based teams (CBT) and 15 hospital-based teams (HBT). Two members from each team volunteered to complete questionnaires regarding their attitudes about teamwork, team process and team performance. They found that although there were differences in the percentage of responses, both CBT and HBT identified similar benefits and limitations of teamwork (88% overlap in these factors). Seventy percent of the CBT members and 83% of the HBT members reported “discipline collaboration” (p.111) as one of the benefits of team work. The other benefit identified was “child/family benefits” (17% of CBT, as compared to 30% of HBT). In addition, 19% of CBT and 15% of the HBT also identified “goal development” as being supportive to their efforts (p.111). Regarding the limitations of teamwork, a number of categories emerged from the open-ended responses. Lack of sufficient “time” is reported to be the greatest limitation for 28% of CBT and 53% of HBT (p.111). This is followed by “lack of communication” (16% of both CBT and HBT), “lack of training” (6% of CBT and 9% of HBT), “lack of commitment of others” (9% of CBT and 19% of HBT), “conflict” (9% of CBT and

6% of HBT), “personality differences” (2% of CBT and 6% of HBT), “lack of value of fellow team members” (9% of HBT) and “lack of consensus” (9% of the HBT) (p.111).

Research on multidisciplinary teams in children’s mental health

Multidisciplinary teams in children’s mental health services provide assessment and treatment to children and youths who experience emotional or behavioural difficulties, or mental health problems. The main types of disorders which are referred to children’s mental health services include substance-related disorders, suicidal tendencies, eating disorders, mood disorders, and attachment disorders. Mental health problems may occur as a result of environmental risk factors such as neglect, dysfunctional family life or witnessing violence. The tasks of the MDT in the children’s mental health area tend to be more complex than MDT in special education whose decisions produce IEPs and placement decisions. The scope of MDT in children’s mental health typically includes evaluation, treatment, coordination and implementation of Individualized Family Plan (IFP) or Wraparound. The Wraparound approach is one of the primary strategies for serving youth with high needs in mental health in the United States, particularly those with severe emotional and behaviour disorders (Rosenblatt, 1996; Burchard & Schaefer, 1992). The task of Wraparound is to devise an individualised, strength-based plan through partnership with families, community services and agencies (Faw, 1999, cited in Walker & Schutte, 2005).

Bloom and Parad (1976) surveyed 1445 community mental health practitioners and 67 directors of mental health training programmes about their attitudes and the nature of their interdisciplinary practice both within their own organisation and in interactions with other organisations. The respondents included

psychiatrists, psychologists, social workers, nurses and mental health workers, as well as training programme directors of these four disciplines. As a whole, the practitioners reported that 60% of their interactions involved members of other disciplines and 40% were with members of their own discipline. Over 75% of the respondents believed that many of their tasks may be best carried out by a means of an interdisciplinary approach such as mental health consultation, working with the community groups, staff training and supervision, family and group treatment, mental health education, after care and rehabilitation services, interagency collaboration. With regard to team functioning, 85% of the respondents indicated that there was a formal procedure for regular team meeting and most teams had a leader; consensus could be achieved after a full team discussion (78%) and contributions were judged by merit than status (85%). While the teams shared the responsibility for assessment and planning, 85% of the respondents indicated that typically one person was responsible for treatment delivery. Two interesting findings emerged from the result of this study: first, most practitioners and directors were positive about the advantages of multidisciplinary practice and training. However there were significant differences by the four disciplines in terms of their multidisciplinary attitudes and practice and almost all directors believed that creating such programmes would increase cost and administrative problems. Secondly, the practitioners' ratings mirrored closely with that of the training programme directions. For instance, the psychiatrists reported the highest amount of interdisciplinary involvement in their practice while the directors of the psychiatric training programmes reported that their programmes offered the greatest opportunities for multidisciplinary training than the other three disciplines. Practicing psychologists scored the lowest in their interdisciplinary attitudes while the directors of the psychology programmes showed the lowest desirability in providing

multidisciplinary training. Nurses and social workers scored the highest in their interdisciplinary attitudes while the directors of the nursing and social service programmes showed the great interest in providing interdisciplinary training.

Radcliffe and Hegarty (2001), collected data using three different approaches: interviews with the team leaders, the researcher's impression and IP meeting records. The authors studied 8 teams in a residential facility over the period of two years in order to evaluate whether the meeting objectives for individual planning (IP) were achieved. The participants were members of the multidisciplinary teams for 8 residents with Autism or Asperger's Syndrome. After consulting with the registered managers who were considered the most knowledgeable with the overall operation of the IP programme, eight specific IP meeting objectives were identified:

1. "Every individual should have an IP meeting three months after admission and annual thereafter".
2. "The client's key-worker should write a report for the meeting".
3. "A multidisciplinary team should attend each meeting".
4. "The key-worker report should be circulated by the chairperson to all attendees at least one week in advance of the IP meeting".
5. "Aims and objectives of the previous IP meeting should be reviewed in the meeting".
6. "Current issues should be discussed in the meeting".
7. "The meeting should agree on a set of objectives for the future".
8. "The chairperson and the key worker should ensure that the IP meeting's aim and objectives were incorporated into the day to day programmes of the client" (p. 91)

The meeting objective is considered “achieved” when it is shown to be met in at least 75% of the meetings, otherwise it is considered “not achieved”. Objectives 1, 2, 6 and 7 were considered achieved according to the IP records, team leaders’ perceptions and author’s observations. Objective 4, 5 and 8 were not achieved according to IP records, team leaders’ perceptions and author’s observations. There were disagreements however on objective 3: the IP records showed that this objective was met while the leaders’ perception and the author’s observation indicated otherwise.

The results of this study suggested that IP meetings occurred on scheduled times, a report was written by the client’s key-worker prior to the meeting, current concerns were discussed during the meetings and future IP goals were generated and agreed upon. However, despite the fact that a current report by the key-worker was prepared for the meeting, it did not always get distributed to the team members before the meeting. This suggested that poor management on the part of the chairperson and this might result in members arriving in the meeting poorly informed of the client’s current situation. Further, the fact that a full team was not always present may raise a question here: were members given enough to attend the meeting or was there a commitment issue involved? Finally although the IP goals were set as a result of each meeting, there was no evaluation or monitoring in place to make sure they were being appropriately implemented.

Research on multidisciplinary teams using independent observers

Data based on the self perception of survey participants are subject to errors in reporting. For instance, interpersonal conflicts between members may influence their perceptions of the overall team functioning. Retrospective accounts of what occurred

during the meeting two weeks before may not be entirely accurate. In order to avoid the subjective bias which may arise in the self-reporting of members' perceptions and to avoid relying on retrospective accounts, a number of studies have used direct observation of team meetings to assess the team process.

Bailey, Helsel-Dewert, Thiele and Ware (1981) used a methodology of independent observers to rate the members' meeting behaviour. Participants were all members of a MDT at a residential facility for children with profound and severe intellectual disabilities. Twenty-three Individualised Programme Plan (IPP) meetings with a total of 160 members were observed at the residential facility. The median team size was seven and the average meeting duration was 79 minutes. Participants were educational staff, paraprofessionals, unit managers, psychologists, physical therapists, and parents or guardians. The two observers sat apart from the group and each rated half of the members in the group. At the end of the meeting, the participants completed a survey containing demographic information, the three self-report items on the Rating of Individual Participation in Teams scale (RIPT) (Bailey & Helsel-DeWert, 1981, see Appendix 7) and rated their own meeting behaviour on the nine statements developed by Yoshida, Fenton, Maxwell and Kaufman (1978).

The results showed that on a scale of 1 (low) to 5 (high) the professionals were rated high on items of "providing information" and low on items of "group process"; in particular item 8 suggesting goals/strategies and item 13 suggesting interdisciplinary goals/activities received ratings of less than 2 (p.252). This suggested that team members were actively contributing information during the meetings, but made very few suggestions on goals, strategies and on interdisciplinary activities.

The same data was re-analysed by Bailey, Helsel-Dewert, Thiele and Ware (1985) in order to examine the difference of observed and self-reported meeting

behaviour by professional groups. The same participants served on 23 team meetings were divided into three professional groups: professionals (n=92), para-professionals (n=26) and direct-care staff (n=36). The professional group included administrative personnel, nursing staff, educational specialists, psychologists, therapists and social workers. The para-professional group included those who implement the IPP or collect data on IPP. The direct-care staff included those who are responsible for care duties such as bathing and feeding. Overall, professional and paraprofessional groups received higher ratings than direct care staff. In particular, significant differences were found on 7 items between the professional group and direct care staff: “seeking information”, “suggesting goals or strategies”, “providing feedback”, “group discussion”, “flexibility”, “accepting responsibility”, “suggesting interdisciplinary goals or activities” and “body language” (p. 438). The professional group received higher ratings on all 7 items than the direct care staff. The paraprofessional group received significantly lower ratings than the professional group on item 8 suggesting goals or strategies; and were rated significantly higher than the direct care staff on item titled seeking information.

All members were asked to rate their own participation following the meetings. All three professional groups reported that their presence was important to the team (means ≥ 3.9). No significant difference was found on any item between the paraprofessional group and that of the other two groups. However, direct care staff reported significant lower ratings on statement 1, 3 and 6: “I usually contribute information”, “I can comfortable disagree” and “I usually evaluate alternatives” (p439).

The results of this study suggested that although all professionals perceived their presence at the meeting as important, there were distinct differences in the

observed behaviour between the professional groups. Direct staff generally participated less in the group process than the members from the other two groups. Team members' participation behaviour was influenced by their status hierarchy. The results of this study clearly demonstrated the reported differences between two methodologies; the members' self ratings did not reflect the meeting behaviour as observed by independent raters.

Hinojosa, Bedell, Buchholz, Charles, Shigaki and Bichhieri (2001) also described the collaborative process of an early intervention team which was part of the EI services within a large medical complex. The team was observed for a 6-month period through semi-structured interviews and video/audio recordings of team meetings. The 7 key members of the team included a social worker, a physical therapist, an occupational therapist, a speech-language therapist, 2 teachers and a teacher assistant. The data was analysed qualitatively and several findings emerged. First, rather than incorporating the child's needs holistically, the team was divided by conflicts in members' practice philosophies. This led to two obstacles in the process of collaboration: a) the programme was operated as two separate plans for the child's educational- and medical needs and b) the educational members felt subordinate in their contributions to that of their therapist counterparts in a medical setting. Secondly, there was little support in the system for collaborative process in terms of time and space. For instance, the therapists could attend meetings as long as they managed their caseloads and it was hard to find a place suitable for the team meetings. As a result, some members did not show up at meetings or came late and stayed only to report their part and left. Further, there was no appointed facilitator or coordinator. Different people took the lead to facilitate the meetings on their own initiatives and the head teacher complaint that she "felt like a manager" as the classroom was used

by other members as a station for information exchange. However in the meetings, different people took the lead to facilitate the meeting. Finally, there appeared to be clear patch protection issues as there were little discussions or input from other disciplines in the process of decision-making. Members also identified that what supported that process was that people tried to “get along with one another and respect what others have to say and offer” (p.216). It would appear that the team in this particular study had minimal support from the organisation to do collaboration work. The team purpose was unclear and the team members appeared to work independently from each other. The philosophical conflicts and the status issues surrounding the team had an unfortunate impact on the team process which resulted in very little collaboration in sharing ideas and strategies.

As described earlier, Wraparound programmes were developed in response to the need for individualised services for children with serious emotional and behaviour disorders. Efforts have been made to assess the wraparound planning meeting using less subjective methodologies. Two studies assessed the wraparound team planning meetings and their results would be described as follows (Epstein, Nordness, Kutash, Duchnowski, Shrepf, Benner & Nelson, 2003; Walker & Schutte, 2005).

Epstein, et al. (2003) observed 112 Wraparound planning meetings involving 63 families in order to assess the essential elements of the Wraparound process as identified by Goldman (1999). According to its authors, the Wraparound Observation Form – Second version (WOF-2) is an empirically validated instrument designed to reflect and evaluate the quality of wraparound teamwork. WOF-2 consisted of 8 subscales: community-based services (5 items), individualised services (9 items), family-driven process (10 items), interagency collaboration (7 items), unconditional care (3 items), measurable outcomes (3 items), management of team meetings (5

items), and care coordinator (6 items). Each item describes the desirable behaviour which reflects the characteristics of effective wraparound planning according to Goldman (1999). Two observers trained in the use of WOF-2 were introduced prior to each meeting and members' consents were obtained. The two observers then marked independently "yes", "no" or "not applicable" on each item during the meetings. Meetings were attended by 2 to 10 members. Amongst the professional members, therapists were the most frequent participants (38%), followed by health/human services (21%), and social workers (21%).

The authors found that for the for community-based service subscale, the desirable behaviour occurred in 77% of meetings. In particular, "information about resources intervention in the local area is offered to the team" (97%), "plan of care included at least one public and/or private community service" (97%). For individualised services subscale, the desirable behaviour occurred in 92% of the meetings. In particular, during 99% of the meetings, "all services needed by the family were included in the plan", "barriers to service or resource/intervention were identified and solutions were discussed" (98%), "the steps needed to implement the plan of care were clearly specified by the team" (95%), "plan of care that included life domains goals, objectives and resources/intervention was discussed or written" (99%), and "safety plan/crisis plan was developed/reviewed" (83%) (p.356). For family-driven process subscale, the desirable behaviour occurred in 98% of the meetings. For interagency collaboration subscale, the overall desirable behaviour occurred in 93% of the meetings. In particular, "professionals from other agencies who care about or provide resources/interventions to the family were present at the meeting" (87%), "problems that can develop in an interagency team (e.g. turf problems and challenges to authority) were not evident or were resolved" (99%), "professionals from other

agencies described support resources/interventions available to the community” (93%), and “statements made by members indicated that contact/communication with another team member occurred between meetings” (92%). For the unconditional care subscale, the overall desirable behaviour occurred in 96% of the meetings. For the measurable outcomes subscales, the overall desirable behaviour occurred in 69% of the meetings. In particular, “the plan of care goals were discussed in objective, measurable terms” (93%), and “objective or verifiable information on child and parent functioning was used as outcome data” (94%). For the management of team meetings subscale, the desirable behaviour occurred in 90% of the meetings. In particular, “key participants were invited to the meetings” (90%), “current information about the family’s current situation was shared before or at the meeting” (99%), and “plan of care was agreed on by all present at the meeting” (100%) (p.357). For the care-coordinator subscale, the desirable behaviour occurred in 85% of the meetings. In particular, care coordinator “made the agenda of meeting clear to participants” (72%), “reviewed goals, objective interventions or progress of plan of care” (96%), “directed team to revise/update plan of care” (96%), “summarised content of the meeting at the conclusion of the meeting” (67%), and “set next meeting date/time” (94%) (p.358).

These results indicated that the team processes this study reflected the principles of wraparound service during the wraparound planning process and overall all a high standard of wraparound services was delivered. For example, key members were invited to, and were present at the meetings. Members communicated with each other about the new development occurring in between meetings which was presented and discussed with all present in the meeting. The team also reviewed the progress of the plan and resolved any problems which came up during the plan implementation or conflicts during meetings. Team members offered suggestions and strategies which

covered all the needs of the family, and the family was offered choices of public/private/community services. The written plan set up specific steps in measurable terms about the goals of the plan and the outcomes expected. Mostly impressively there was 100% consensus on the plan which indicated all members were satisfied with the plan as a result of quality team process. Interestingly this was a rare study which investigated the specific role or function of the coordinator; such as making the agenda clear in the beginning of the meeting, reviewing the plan, direct or redirect the topics of discussion, summarising the meeting results at the end, coordinate next meeting. The results showed that there were areas of strengths and improvement to be made for the coordinators participated in this study.

Walker and Schutte (2005) observed 72 Wraparound team planning meetings of 26 teams and surveyed 242 members about satisfaction on team productivity. Items were coded as “yes” or “no” by independent observers. The meetings were attended by 6 people on average who may include family/caregivers, family support or advocates and professionals. Over 73% of the meetings were attended by more than 3 professionals amongst which mental health managers/care coordinators were the most frequent participants (93%), followed by child psychotherapists (54%), mental health supervisors (26%), school counsellors (33%), child welfare case workers (14%), lawyers (13%), and school teachers (8%). In 72% of the meetings the team “*mentioned specific strength of the child/family*”, “*discussed its overall mission*” (51%), “*maintained an updated minutes*” (46%) and “*provided a written agenda for the meeting*” (42%) (p.260). However, only 31% of all meetings observed did the teams develop specific plans and goals, review systematically whether assigned tasks were accomplished (29%), have a clear structure for the meeting proceeding (25%), have at least one goal associated with specific measurement criteria (24%), generate

several distinct alternatives before making decisions (20%), and engage in brainstorming (13%). In less than 10% of all the meetings observed did the teams use a clear structure to prioritise goals/strategies, elicit opinions from each member (e.g. go around) and have clear ground rules for interpersonal conduct during meetings. The survey results showed that on a scale of 1- 10 (least to most), the mean rating of interpersonal relationships during the meeting was 7.89 and the mean rating for team productivity was 8.07. When asked what was best thing about the meeting, “sharing thoughts/opinions openly” was identified by 32% of the respondents, followed by “sense of hope/efficacy” (14%), “team members collaborated well “(12%), “members sharing important information” (12), “team had good camaraderie” (11%), and “family centred” (9%). When asked what the worst aspect of meetings, 22% of the respondents replied that “important people absent”, “lack of focus” (17%), “team atmosphere did not promote open/productive communication” (17%), “members did not cooperate” (8%), and “difficulty including the youth in the meeting” (7%) (p.260).

Although many researchers have made careful attempts to specify meeting behaviours when developing their instruments, independent observer ratings remain in essence subjective data. Therefore the following two studies used direct observational method in which the data were coded numerically in order to preserve their objectivity.

Goldstein, Strickland, Turnbull and Curry (1980) observed 14 Individualised Education Programme (IEP) team meetings to investigate what was being discussed during the meetings. The authors used a coding instrument to record what was being discussed and by whom on a two minutes time interval. The team sized varied between 2 to 6 members and meetings and the average meeting length was 36 minutes. In 9 of the 14 meetings, a full team was not present and the missing participant was the professionals of the public agency. The most frequent participants were resource

teachers and the parents who were present in 100% of the meetings, followed by classroom teachers (43%), interns (36%), principals (21%), counsellor (14%), speech therapist (14%) and reading teachers (7%). The results showed that resource teachers spoke on average 9.6 times per meeting, followed by parents (mean=4.5), classroom teachers (mean=3.5), counsellors (mean=3.0), speech therapists (mean=1) and reading teacher (mean=1). In addition, 46% of the meeting discussions were related to information about the student's behaviour, performance, health and family issues, 20% on goals and objectives of the curriculum, followed by meeting proceedings (12%), placement options (4%), special services available (4%), individual responsible for actions (1%) and future contact/review (1%). It appeared that the resource teacher dominated the meeting who spoke twice as more as the parents. Other professionals who may have valuable contribution about the child had not actively participated. For instance, the classroom teachers spoke only four times and speech therapists only contributed once. Nearly half of the meetings were spent on providing information about the child and the family and there were only 5% of the time was spent on what to do in order to achieve the IEP goals.

Ysseldyke, Algozzine and Allen (1982) observed the regular classroom teachers' participation behaviour during 24 multidisciplinary team meetings for special education placements. Data on teachers' comments were collected by using a 10 second interval method while reviewing the video tapes of the meetings. A frequency count of how often others elicit teachers' contributions was also noted. The average length of the meetings was 31 minutes and the average team size was 7.4 members. Ysseldyke et. al found that regular classroom teachers made 27% of the total contributions. Forty-three percent of the teacher's comments were about the child's "classroom behaviour", 47% were "subjective/irreverent comments" and 10%

were “assessment information”. In additions, the regular classroom teachers were asked 6 questions per meeting and, test information and recommendations were only elicited 9 times out of 24 meetings. The results suggested that teachers made a good amount of contribution (over one quarter on a team size of 7). However nearly half of their comments were irrelevant or personal opinions and they made less than one recommendations per meeting.

Ysseldyke, Algozzine, and Mitchell (1982) videotaped 34 IEP meetings in order to evaluate the team effectiveness. Two observers reviewed the tapes and scored each item independently with a “yes/no” format. Team members included psychologists, learning disabilities teachers, regular classroom teachers and parents. The average meeting duration was 31 minutes (ranged 5 to 57 minutes) and team size was 7.4 (ranged 6-16 members per team). Ysseldyke et al. (1982) found that the purpose of the meetings was clearly stated in 35% of the meetings and in 12% of the meetings that there was a statement about the decision(s) to be made. In all of the meetings, the roles of the team members were never clearly defined. There was no attempt made to encourage members’ participation and no mentioning of improving team functions as an additional goal. Information was presented in meaningful manner (i.e. no unexplained scores on diagnostic tests in children’s records) in 81% of the meetings and both the child’s strength and weakness were discussed (75%) which was seen as an important part of the meeting. Child’s daily behaviour as well as the academic data were provided (84%). However, only in 6% of the meetings was the information based on systematic observation presented. The teams spent more time discussing the needs of the children than generating alternatives. Decision(s) was (were) made in 88% of the meetings but there was no evaluation of the decision(s) and no consideration of the least restrictive alternatives for placement or services in

any of the meetings, as required by the IDEA law. Finally, none of the team evaluated whether the goals generated for the child were achieved as a result of the meetings.

Research on multidisciplinary teams in New Zealand

Although collaboration does exist informally between professionals and teams have been formed on a local level, little research is available about local collaboration. It is a common practice amongst child and adolescent service professionals to communicate about their shared client through phone calls and emails. Although professionals may work with each other, the nature of collaboration is often limited between individuals and, apart from information exchange, no collaborative actions may result from such informal networks. A multi-disciplinary team often arise out of local initiatives when various agencies come together to set up a committee for a particular project. For instance, in order to improve the outcomes of young people living in Christchurch, the Christchurch Social Policy Interagency Network group (CSPIN) is formed from members of the Christchurch City Council, police, and key social sector government agencies in the city. CSPIN sought views from all of its members and developed a three year plan to address collaboratively the key issues impacting on the young people in Christchurch (Christchurch Social Policy Interagency Network, no date). Many MDTs like this have occurred throughout New Zealand at an operational level; however there has little formal reporting or evaluation of schemes such as these.

Strategically, policies have been and continue to be developed on a regional or national level to guide the collaboration effort and the majority of the New Zealand literature on MDT focused on this level of collaboration. There are three significant

New Zealand government commissioned reports on this subject: *Views on inter-agency collaboration and the Strengthening Families Collaborative Case Management Initiative: a report on the results of a survey*, (Visser, 2000); *Mosaics* (Ministry of Social Development, 2003) and *Stocktake of child and adolescent mental health services in New Zealand* (Ramage et al., 2005). They all explore the potential facilitators and barriers to collaboration.

Strengthening Families is a government strategy to provide more coordinated services to children and young people who are at risk of poor outcomes. It is a collaborative case management process expected to happen when more than one agency is involved in the care of a child or young person. When a Strengthening Families meeting or case conference is initiated, a case management team involving all key agencies is formed to develop a collaborative plan for this particular child or young person. Visser (2000) surveyed 643 professionals about their attitudes towards collaborative teamwork. Participants were government employees who received Strengthening Families Case Management training between 1998 and 1999. Of these 24% worked in health, 47% in education and 29% in welfare sectors.

Visser found that 99% of respondents believed that the idea of working together more closely was a good one and their clients were better served this way (91%). However, 61% of them said that the Strengthening Families concept was not new to them and they were working in this way already; some commented that Strengthening Families “simply formalised what they had already been doing” (p.79). In terms of support, 91% of the respondents felt that their managers were supportive of Strengthening Families and 83% said that their colleagues were supportive. Although respondents were generally positive about collaborative work, 62% of them agreed that being the lead agency meant extra work for them and only 10% of them

were willing to take on this role. As many as 56% of the respondents said that Strengthening Families did not increase their contact with other agencies and 43% of them said that Strengthening Families had made no difference to their work practice. Further, 43% of the respondents felt that not all agencies were willing participants; it is sometimes difficult to come to an agreement on a shared plan (31%).

Several factors were identified which facilitated the collaborative process: having contacts was identified by 24% of the respondents, having good communication by 11% of the respondents, sharing information (15%), sharing work responsibility (8%), sharing resources/funding (6%), commitments including participation and resourcing (15%). In addition, clear roles and responsibilities (16%), regular meeting time and place (14%), a good facilitator (8%), set protocols to follow (10%) were also said to be important elements for successful meetings. Barriers to collaboration included lack of time (20%), lack of resource/funding (16%), lack of commitment (11%), personality/view differences (12%), too heavy caseload (8%), secrecy/inaccurate information (7%), poor communication (6%) and lack of clarity about roles (6%).

A key report *Mosaics* by the Ministry of Social Development (2003) explored the practice of collaboration using the focus group approach. Three regions with distinctively different social, economic and environmental characteristics were selected in order to represent the diversity of collaboration models: Taranaki, Manukau Counties and Southern (Southland and Dunedin) regions. Participants were individuals from government departments; community and NGO groups; Maori- and Pacific Island groups; and local government and business sectors who were either involved in existing collaboration initiatives or had interest or experience in the delivery of these services. A series of focus group discussions were conducted in the

regions. Participants shared their experiences of collaboration: barriers to successful coordination and integrated service delivery were identified. The four main areas identified were: organisational culture of secrecy and not open to collaborative work; different funding processes which were inflexible which made it difficult to plan long term collaboration, inconsistent service boundaries within government structure and systems which meant that there was no single point of contact person to coordinate the issues concerned; and lack of awareness of policy makers resulted in development at national level poorly aligned with local priorities.

One of the objectives of the Stocktake project (Ramage et al., 2005) commissioned by the Ministry of Health was to identify the barriers to interagency coordination in the child and adolescent mental health services in New Zealand. A total of 150 General Practitioners (GPs) and 37 child and adolescent psychiatrists were surveyed about their views on barriers to interagency coordination. The greatest barriers identified were the Privacy Act and confidentiality issues which made it difficult to share client information. Participants also reported that too many agencies were involved which made it difficult to know whom to contact. Most agencies were under-resourced and understaffed which resulted in lengthy response times to liaise with other agencies. There was a need to protect the resources due to funding limitation. There was a lack of policy and dedication from the management to support interagency collaboration.

Most of the facilitators and barriers to collaboration in these three studies were consistent with the international literature. They included difference between agency priorities (Lamorey & Ryan, 1999), resistance to change (Lamorey & Ryan, 1999), time and funding limitations (Pfeiffer, 1981; Hinojosa et. al, 2001; Malone & McPherson, 2004). The New Zealand literature however specifically identified the

Privacy Act as a barrier; information sharing amongst the professionals was limited by the confidentiality issues. Another interesting finding which was unique in the New Zealand literature was that professionals stressed the fact that they have always worked collaboratively with each other and the formal structure of collaboration did not increase the contact they had with each other.

The New Zealand HCN Process

As compared to other forms of collaboration mentioned in the above New Zealand literature, an IST of the HCN process is highly structured and formalised. For instance, the pooling of financial resources is required; member's attendance at IST meetings is mandated, the leadership (that is, LSC) is assigned to the team as opposed to being elected from within the team. The teams follow HCN protocols and a strict schedule of quarterly plan reviews. There is a clear role and responsibility for each team member based on the different areas of need of the child or the young person. For instance, the professional from the Ministry of Education will by default be responsible for the young person's educational needs.

In terms of membership, an IST consists of professionals from the three sectors (MoE, MoH & CYFS). Typically, an IST meeting may also involve family and contracted service providers of previous or ongoing services to the child or young person, such as the mentor, tutor of a special training programme, or the caregiver of the child or young person. The LCS plays an important role in coordinating and facilitating the meetings and also updating team members with any new development concerning the child or the young person in between the meetings.

The HCN process as established by the three sectors involves cooperation at each step. In order to initiate the process, a child or an adolescent is identified by a

professional from one of the three sectors (Health, Education and Welfare) on his or her caseload as having exceptional needs across at least two sectors. The professional then approaches professionals from the other sectors to form an intersectoral team (IST) to begin the application process. Members of the IST then collates assessment information including current and past services, strengths and needs of the young person and how these needs may be met. Once the necessary documentation has been completed, it is then forwarded for consideration at the local prioritisation meeting. During this meeting, managers from each sector discuss the application and may decide on the expenditure for their sector. This step is to ensure that all local solutions have been explored and that the sector managers are aware of the intersectoral work which is taking place in their area. If the sector managers decide to proceed with the application, it is then submitted to the National Moderation Panel which meets every fortnight. The Panel consists of senior practitioners from each sector who then decide to accept or reject the application, to ensure that those with the highest needs across the country receive appropriate resources. Plans are generally approved for 12 months with the possibility of extension to a further 12 months. Once the application is approved, a Local Service Coordinator (LSC) is assigned to the team to convene a meeting to develop a plan for the targeted child or young person generally within six weeks. IST then identifies goals or objectives to be achieved; works out steps and strategies to achieve these objectives; shares current knowledge and best practices for the unmet needs; determines services to deliver the plan and how the services will be deployed and decides on the desired outcomes and outcome measurements. The plan is then signed off by managers of each sector involved. This signifies the commitment and the support of the IST. The plan is then implemented to deliver the proposed services and interventions within the plan. IST

meets at least every three months for plan reviews but may meet more frequently when needed, especially in the early stages of the plan implementation. The plan is evaluated and modified if necessary; new goals are generated when current ones have achieved their intended outcomes.

Summary

A summary of facilitators and barriers identified in the literature is presented in Table 1. Three professional attitudes are categorised as positive for collaborative teamwork and 7 attitudes are considered negative for collaboration. Six individual behaviours are said to be conducive to positive meeting outcomes. These are: having an experienced coordinator, knowing each other and the services that each provides, attending the team meetings and actively participating in the meeting. In contrast, 9 individual behaviours are associated with poor meeting productivity. They include: members lateness or absence from meeting, lack of contribution or cooperation, lack of effective leadership skills, lack of training in team-building, inadequate skills, and meeting difficulties caused by the presence of client at the. Six contextual factors which foster collaboration are: sufficient time devoted to team building, contact between members between meetings, government support in developing policy for collaboration, support from the agency, and shared resources. Eleven contextual factors are reported to hamper collaboration, for examples, overworked staff, lack of administrative support and competency, lack of time, financial limitations, competitive organisational culture, the number of agencies involved, a lack of long term vision for collaboration and lack of infrastructure for meetings. Twenty three collective team behaviours and 15 negative team behaviours were also identified.

*Table1**Summary of Facilitators and Barriers Identified in the Literature*

| Factor Category | Positive or Facilitating | Negative or Barriers |
|----------------------------------|---|---|
| Professional Attitudes | <ul style="list-style-type: none"> • resolution of role, turf status issues • positive attitude and belief regarding advantages of multidisciplinary practice and training • respect for professional opinions and contributions | <ul style="list-style-type: none"> • lack of interdisciplinary trust or collaboration • lack of commitment of others • lack of encouragement of members' participation • philosophical differences among team members • resistance to change • lack of value of fellow team members • status issue and turf protection |
| Individual Behaviour at Meetings | <ul style="list-style-type: none"> • effective leadership • good interpersonal relationships • sufficient knowledge about specific goals and services of the other agencies • prior relationship with staff at other agencies • full meeting attendance • active participation and contribution | <ul style="list-style-type: none"> • lack of experience or training of leadership • absence of key participants • lack of bilingual staff • lack of training in team building/maintenance • personality differences • late arrive or early departure • unwillingness to cooperate • difficulty including the |

| | | |
|-----------------------------------|---|--|
| | | youth in the meeting • lack of competency among team members |
| Contextual | • adequate time on team building • supportive state level policies • supportive managers and colleagues within the agency • shared resources and funding • regular meeting schedule • frequent communication with team member between meetings | • overworked staff • lack of administrative support and competency within the agency • competitive organisational culture • lack of time • fiscal restraints • lack of physical space for meeting • Rigid funding process and criteria • lack of integrated services because of structural boundaries • difficulty in knowing who to contact because of the number of agencies involved • lack of long term collaborative vision • lack of awareness of local needs and priorities |
| Collective Team Meeting Behaviour | • ease of information sharing • jargon-free communication • objective and measurable goals | • lack of meeting coordination • negative team atmosphere |

- shared responsibility
- agreement of decisions or consensus
- balanced discussion on both strength and needs of the client
- sufficient background information and current concerns about the client
- agreement of goals for the client
- clear meeting agenda
- systematic review of goals, assigned tasks and progress of plan
- summary of meeting decision and action items at the end of meeting
- confirmation of next meeting date/time
- adequate local resources and services
- well designed plan covering all aspects of the client's needs
- identification and resolution of problems to intervention plan
- clearly specified steps to implement the plan
- development of crisis plan
- well maintained and updated minute
- unclear meeting purpose and procedure
- lack of consensus
- lack of service options
- lack of plan evaluation
- lack of communication
- lack of systematic decision-making
- lack of role clarity
- lack of attention to team process
- inequitable distribution of workload
- unclear team philosophy and long term goals
- lack of objective data about the client
- lack of consideration of the least restrictive alternatives for placement
- difficulties in information sharing because of Privacy Act

- clear meeting structure and proceeding
- exploration of several distinct alternatives
- prioritisation of goals and strategies
- elicitation of each member's opinions
- clear ground rules for interpersonal conduct during meetings.

Other

- effective follow-up services were available
 - increased skills for members as a result of participating in teams
 - objective and verifiable measures for outcomes
 - better relationships with other agencies
 - increased personal and job satisfaction
 - client improvement
 - lack of appropriate follow-up
-

Research aims

Literature on MDT in children and adolescent services has not been well researched. New Zealand literature on this subject is even more limited. Most studies in the literature used self report via interviewing and questionnaires to collect data and there have been very few studies in the literature which have used objective data. To date there has not been any New Zealand study on the topic of MDT using the direct observational method. An IST of the HCN process appears to be one of the most structured MDT in New Zealand as compared to other forms of collaboration. There are two research aims in this study:

1. to describe some of the team process of the intersectoral teams of the High and Complex Needs Unit in the New Zealand context using direct observational method.
2. to describe perspectives of some of the participants of the intersectoral teams of the High and Complex Needs Unit in New Zealand.

Chapter 3

Method

Research design

This research is a descriptive study of the team processes of three intersectoral teams for children and young people with high and complex needs in the South Island, New Zealand. Two methods were used to collect the data: semi-structured interviews and direct observations.

Recruitment

A meeting with the South Island HCN Plan Advisor was set up to develop the research plan. After full consultation with the South Island HCN Plan Advisor, agreement with HCN was formalized. A letter to the University of Canterbury Human Ethics committee, an information sheet and the consent form were finalized as a result of this meeting (see Appendix 1 for a copy of letter of approval from the Human Ethics Committee, Appendix 2 for a copy of the information sheet, and Appendix 3 for a copy of the consent form). Initially four teams led by two Local Service Coordinators (2 team each) were recruited by the South Island HCN Plan Advisor. Information sheets and consent forms were mailed to the two Local Service Coordinators (LSC) who convened the team meetings for particular cases. Information and consent forms were then distributed to the team members. Those who indicated their willingness to participate in the interview returned the post-paid consent form to the researcher. They were asked if data could be recorded during intersectoral team meetings. As the family of one particular young person did not give consent for the meetings to be observed, three teams were included in this study

which returned a 47% response rate. These three teams were convened for “Sam”, “Chris” and “Alex” and therefore are referred to as Team “Sam”, Team “Chris”, and Team “Alex” thereafter.

Participants who returned the consent forms to the interview were contacted individually by telephone to arrange for a semi-structured interview which would take approximately one hour. They were told that all data including their demographic information would be kept confidential and no identifying information would be mentioned in the report. Individuals had the right to view the data collected and make corrections. The quotations in the report would not be linked to any person, position, or agency and statistical summaries would be used where possible.

Participants

Participants of this study were 3 Intersectoral Teams (IST). Each team consisted of professionals from the Department of Child, Youth and Family Services of the Ministry of Social Development, Group Special Education of the Ministry of Education, Christchurch District Health Board, Justice Department and non-governmental organizations. Other team members present were family, support persons and sometimes the young persons whose data were not recorded and were not included in this study. The team size varied from seven to eight professional members and three to four members from each team participated in the study including two people who served on two of the three ISTs. The highest qualifications achieved ranged from school certificate to doctorate degree. Members reported they have been employed in their current agency from one to 28 years. The years of HCN involvement were reported to be one to five years although members generally indicated longer informal collaboration experience.

Procedures

An email reminder about the presence of an observer at the meeting was sent to all members of the three teams by the Local Service Coordinators prior to the meeting. The observer waited outside the meeting room while the Local Service Coordinator obtained oral consents from the members present. In the case where the family and the young person were present, it was explained that the purpose of this study was to observe the professionals' participating behaviour during the meeting and no data would be collected on the family or the particular child/adolescent concerned. Once consent was obtained from all present, the researcher was brought in and introduced before the meeting started. It was decided prior to the meeting that a maximum of six professionals would be observed per meeting in order to maintain the quality of observation. A simple random sampling strategy was used and six names were drawn from the pool of those consenting. Two meetings from each team were observed following the same procedure.

Instrumentation

Data were collected from two sources: semi-structured interviews and direct observations of meetings

semi-structured interviews. The development of the questions for semi-structured interviews was based on the conceptual framework of the Interagency Collaboration Model (Polivka, 1995; Polivka Kennedy & Chaudry, 1997) which has its origin in assessing interagency collaboration among mental health agencies (Morrissey, Tausig, & Lindsey, 1985, cited in Polivka et al., 1997). This model proposed that interagency collaboration is a complex process which can be viewed as

a function of five major constructs: environmental factors, situational factors, task characteristics, interagency processes and outcomes. Environmental Factors are the macro level within which the collaboration operates. This includes the broader political, economic, and social policies that promote, mandate or discourage the practice of multi-agency collaboration. Situational factors are aspects of organisational culture or regulations which contribute to the strength of the interagency relationships, for instance, how well professionals know each other and the awareness of goals and services of other agencies. Task characteristics are what are involved in the joint project and the skills and resources necessary to achieve such project. Interagency processes describe the degree to which information and resources are shared during collaboration. Outcomes include the effectiveness of the programme and satisfaction in interagency relationships. The interview questions were discussed and reviewed with the South Island HCN Plan Advisor who is familiar with the overall operation of HCN. (see Appendix 4 for a complete list of interview questions).

meeting observations. The instrument used for meeting observations was adapted from that used by Bailey and Helsel-DeWert (1981). An observational instrument was developed from the original coding sheet used to collect data (Bailey & Helsel-DeWert, 1981). Data were recorded using a frequency tally on a sentence by sentence basis. Following the observation, the observer then numerically summarise the frequency of each observed behaviour (See Table 2. for descriptions of the instrument).

Table 2

Descriptions of Instrument

| Subscale | Categories | Descriptions |
|-----------------------|--|---|
| Providing Information | Volunteer | Share information about the client voluntarily without being asked. Volunteer |
| | Asked | Share information about the client when asked by others and the information is more than simple yes or no |
| | Jargon | Share information using unexplained technical terms not understood by others |
| Seeking Information | Questions asked | Raise a question or an issue for discussion |
| | Elicit elaborate responses | Raise a question or issue which elicits elaborate responses or discussions. |
| Goals/Strategies | Suggestions made | Make a suggestion for goals, objectives, or implementation strategies |
| | Suggestions including rationale/feasibility/client acceptability | Make a suggestion which include rationale or discussion of feasibility and acceptability of service to client |
| | Interdisciplinary suggestions | Suggest interdisciplinary activities which involve the cooperative efforts of two or more disciplines |
| Feedback on Goals | Feedbacks given | Give feedback on goals suggested by members in socially and professional manner |

| | | |
|---------------------------|---|--|
| | Elaborate feedbacks than disagreement/agreement | Give elaborate feedback on goals or strategies suggested by members |
| Decision/Responsibilities | Refuse responsibility | Refuse or avoids accepting responsibility |
| | When asked | Accept responsibility when asked |
| | Volunteer responsibility | Volunteer to accept responsibility |
| | Rigid | Show unwillingness to modify opinions or recommendations |
| | Team decision | Goes along with team decisions |
| | Joint solution | Collaborate with team members to reach a joint solution |
| Group Participation | Discouraging | Discourage others from participating |
| | Solicits other's contribution | Solicit contributions from other team members |
| Distractions | Unpunctuality | Arrive late or depart early |
| | Distracting behaviour | Exhibit distracting behaviours such as whispering or tapping pencils |
| Non-Verbal Behaviour | Boredom or dissatisfaction | Look away or display disinterest |
| Others | | Any other comments or behaviour not listed above |

Chapter 4

Results

The results section is divided into two parts: interviews and observations of meetings.

Interviews

Nine people were interviewed and their individual responses were described as followed (see Appendix 6 for compiled responses).

1. How well does your agency support local collaborative efforts?

When asked how well they felt their agencies supported local collaborative effort, 3 of the respondents replied that they felt there was little or no support from their agencies. One person stated that collaboration as a principle was encouraged by their agencies. Two people felt that the agency offered support in terms of finance and policy. Two people said that that they felt their agencies were supportive or support the collaborative effort extremely well. One person did not answer.

2. Does being involved in IST change your role? If so, how? If not, why not?

Six people said being involved in IST did not change their roles because it does not change their job or responsibility. One person said her role has changed from crisis management in her normal cases to professional consultancy in HCN cases. Another person replied that the role has changed his or her way of approaching the problem and has given him or her more contact with other agencies. One person did not answer.

3. Does your line manager give you sufficient time to take part in intersectoral work?

Five people said “no” to this question and one person said that there was support from his immediate supervisor. Two people said that this question did not apply to them because they make decisions about their own time.

4. a. Do your work colleagues support your involvement in IST?

b. What are the incentives and barriers to your role expansion?

c. What are ways to reduce barriers to role expansion

Six people said they did not get extra support from their colleagues for being involved in HCN. One person said that the support comes from those who had previous HCN experience. Two people did not answer.

5. a. What kinds of training are available to prepare staff for collaboration work within the organisation?

All 9 respondents agreed that there was no specific training within their organisations available for collaboration work.

b. To what degree is the collaboration (info sharing, relationship building) part of your performance assessment criteria?

Six respondents replied that collaboration was expected but not as part of their performance assessment criteria. Two people stated that collaboration is a crucial part of their job appraisals. One person did not answer the question.

6. Please comment on the willingness and interest of your manager/colleagues for cases (intersectoral collaboration) like this in the future.

Three respondents said that their managers were neutral about their involvement in intersectoral cases as long as they managed their normal workload. One person replied “Don’t know”. Two people said that their managers were supportive of their future

intersectoral cases. One person replied that it depended on the budgets and the resources of the agency. Two people did not answer.

7. a. What is your attitude/belief towards intersectoral collaboration?

Five people said that they believed intersectoral collaboration was a good thing and was critical; intersectoral collaboration has been a long time coming and the current process should be further simplified in order to encourage more collaboration. Two people replied that intersectoral collaboration was a good idea as long as it is worked for the client. One person did not respond.

b. What are your views on the strengths and limitations of intersectoral collaboration approach?

Regarding the strengths of intersectoral collaboration approach, 4 people said that the commitment from other team members was an incentive. This is followed by shared financial resources and shared responsibilities/support, as stated by three people respectively. Two people said that it was helpful to have a Coordinator who was “on to it” and took care of “all the logistics of the meetings”. Two people said that the other benefit was that decision-making and problem solving became more efficient. One person also mentioned that there was clear communication with all the professionals involved as a result of collaboration. Two people made additional comments that intersectoral collaboration approach offered far more strengths than limitations.

In terms of limitation, the application process was cited by three people as being “daunting”, “clumsy”, and “time consuming” because of the amount of knowledge and paperwork required. Two people stated that the timeframe is another limitation because one year in general was too short to carry out the plan for youth with such high and complex needs. Interpersonal conflicts such as “talking too much” or

“differences of opinions” were mentioned by two people as a limitation. Two people said that the resources should have been available earlier rather than “let things gone so bad”. It was then hard to reconcile the fact that these youth were provided unlimited funding whereas others who did not meet the criteria received \$10 per week. One person said that an inexperienced Coordinator could make the process difficult: the suggestion was to provide more training or a buddy system to work together with an experienced Coordinator initially.

8. How well do you know the other members from other sectors?

By first name?

How many times have you worked together in the past?

All respondents said that they know other members by first name. Six people said that they know their team members “very well” and two people said they know some members “not that well”. Four people said that they have never worked the other members in the past and 4 people stated that they have worked “hundreds of times” or “at least 40 to 50 times” in the past.

9. How well do you know the specific services of the other sectors?

Are there common elements in the services they provide?

Four people said that they have reasonable or good knowledge about the services of the other sectors. The others did not respond.

10. How important is intersectoral collaboration to the achievement of your agency’s goals?

All 8 respondents said that intersectoral collaboration was “very important” or “vital”. Some comments included that “It is impossible to do this without HCN [structure]” and “Without it the plan will fail”. One person replied “non applicable”.

How do the differences between agencies' priorities and policies affect the intersectoral collaboration process?

Five people stated that the differences in priorities and policies do not affect the process because there are clear rules and expectations. However, 3 people said that the some agencies are so slow in acting because of the long waiting list or complicated procedure. As a result, "things get so much worse" or "it means that the kids have to wait. In the meantime they are missing school and at risk of getting expelled". This question did not apply to one person.

11. What are the types of conflicts (if any) you have noticed during IST meetings?

Three people stated that there was no conflict. Two people said that there was usually "healthy debates" and "nothing big". Two people mentioned that some people did not perform "satisfactorily" or not doing "what they said they would do". One person stated that meetings took too much time and it was a "waste of time". One person did not respond.

12. What kind of processes are in place for recognising and resolving conflict in the IST meetings? (e.g. patch protection/attitude towards collaboration)

Three people stated that they did not experience the need for conflict resolution. Two people said that there was nothing in place for resolving conflicts. Two people mentioned that it is the Coordinator's job. One person said that they were able to come to agreement through "healthy discussions".

13. How is information sharing, openness and transparency achieved at IST?

Five people said that there was openness and honesty and there was no problem in this area. Two people said that the transparency was achieved through the Coordinator. One person stated that people "don't want to rock the boat". One person said that it

was “tricky” to discuss funding allocation while the parents and caregivers were present as this could potentially cause conflicts between the two.

14. In what ways can members support each other informally/formally?

Having more contact and checking in informally was listed by 3 people as a way to support each other. Two people said that there was not much more members could support each other besides than following the plan. One person said that individuals can be backed up by the team to push for things to happen more quickly. Other comments included giving positive feedback about each other’s performance, being professional by being punctual and accountable; contribute more and expressing honest opinions so the team can send consistent messages across to the service providers.

15. What are the existing linkages between agencies (sectors)?

All respondents agree that it is part of their job to link with other sectors because they have common clients. However the linkage is informal and is operated on a “case by case and person by person” basis.

16. How often do you contact other IST members?

All 9 respondents said that the frequency of contact depends on the needs of the client, from weekly (if the plan is new or the plan is not working) to monthly or quarterly when things are going well. Five people stated that they had very little contact with each other outside of the meetings.

17. To what degree do you exchange information with other sectors?

Do you/your agency refer clients to other agencies? Which agencies?

All 8 respondents agreed that there was no restriction on information exchange with other sectors.

18. How productive are IST meetings?

Five people said that the meetings were very effective. Two people said the meetings were productive in some cases but not in others. One person said that the meetings were more productive compared to those of one year ago. One person said that the meeting was not productive.

Are you able to explore more options or strategies for individual cases as a result of IST meetings?

Seven out of 9 respondents answer “yes” to this question, and one person said “no”.

One person replied that it has “potential” to do so.

19. How do you come to agreement about each others’/agency’s roles and responsibility?

Five people said that responsibility was clearly defined by each sector’s role and therefore it was easy to come to agreement. Three people said that members volunteered mostly for responsibilities. One person did not respond.

20. How willing are you (or/and your organisation) to take the lead agency role? Why and why not?

Three people said that they were not willing to take the lead agency role because of the amount of paperwork involved. Three people replied that the Coordinator was employed to be in the lead role. One person said that it was fine for him or her to take this role if need be. One person said that structurally only one of the three sectors (Education, Mental Health and CYFS) can take the lead role. One person did not answer.

21. How much influence and decision-making is shared among members?

Five respondents said that there was equal power in decision-making and hence no problem in this area. Three people mentioned that whoever had the legal status of the child overrode the team decision on guardianship issues. One person explained that

decisions about funding rested on the 3 sectors whereas everyone had equal input into the goals of the plan. One person said that the Coordinator had a huge influence on the team's decision. Others said that it depends on the status, experience or the personality of each member.

22. How easy is to come to agreement of a shared plan?

Six people replied that it was very easy to come to agreement. One of them mentioned that the agreement was achieved through the majority rule. One person said that there was not a real agreement as the plan was made by the Coordinator alone. One person did not respond.

23. How much workload is shared? How satisfied are you with other sector's contribution?

Three people replied that each sector's workload depended on the needs of the clients. Five people said that they were happy with others' contributions. One person did not answer.

24. How is accountability ensured?

Four people said that the accountability was achieved by the mechanism of meetings and in particular by the HCN quarterly review; that accountability was in-built as the full attendance was mandated in the HCN structure. Two persons said that it was up to the Coordinator to remind people and one of them felt that there wasn't any accountability because the Coordinator was not assertive enough.

25. What is the scope/complexity of the intervention plan? i.e. Need diverse specialities to accomplish collaborative goals? What kind of specialities? What are the skills and knowledge needed for your role in IST? Please comment on the capacity to deliver and goal implementation.

Four people said the cases were very complex indeed, however, people had adequate skills to perform their jobs. One person said that apart from one member, the rest of the team had adequate skills. Two people mentioned that skills however were not the limitation here; it was the willingness or the commitment of all three agencies. Two people said that they felt the skills of the Coordinator could “make or break the plan”. One person explained that as members were not required to play the role of a coordinator, they do not need to upskill themselves in the area of meeting facilitation; nevertheless, it would be very helpful to have a booklet so the team members could gain more knowledge on the HCN procedure.

26. How likely to you think plan outcomes can be achieved? How do you anticipate outcomes of collaborative efforts?

Four people said that they were optimistic or confident that the plan was achievable and time was the only constraint here. One person said he or she “hopes so”. One person said that there was a “50/50 chance” that the plan may work due to the difficulties of the cases. Three people also mentioned that ultimately the success of the plan was up to the motivation of the youth concerned. Two people stated that the short term plan could be actioned but they were unsure about the long term goals. One person expressed the concern that in her case the plan was unworkable because there was not enough understanding of the young person.

27. Are the outcome measures [for this particular case] clear and realistic to you?

Six out of 9 respondents answered “yes” to this question and one person said “no”. One person said that the long term goals such as “holding down a job or living independently” were unrealistic. One person said that the outcomes were difficult to measure because it was up to the youth totally.

28. How has increased collaboration changed service to this child/young person and their families? Does the collaboration achieve its intention i.g. help overcome the fragmentation of service, bridging the gaps of services and reduce duplication? Give examples.

Five of the respondents said that the increased collaboration has made a huge impact on the youth and their families in ways such as having more resources available, making the services more productive, providing the best chance ever for the youths concerned, giving hopes when there hasn't been any, encouraging the family to take share responsibility and stop the family from splitting the professionals. Two people said that it made no difference because the parents were not actively involved anyway, and that there has not been enough communications with the family and amongst the professionals. Two people did not respond.

29. Does your involvement with intersectoral collaboration increase your job satisfaction within your organisation?

Five people answered "yes" to this question. One person replied that the HCN case was just one of the routine jobs. One person responded negatively and said that he or she would never want to get involved again: "I would avoid it like a plague". Two people did not respond.

30. Does your involvement with intersectoral collaboration result in more productive and positive relationship with other agencies for your work?

Six people responded "Yes" to this question. One person said that the main reason behind collaboration was to get funding and increased collaboration was secondary. One person responded negatively and said that he or she in fact "lost respect for some people" which "affects my confidence in [making] future referrals". This question did not apply to one person.

31. How does your experience of being involved in IST change the way you work in other cases? do the wider community benefit from IST collaboration effort?

Seven out of 9 respondents said that being involved in IST did not changed their way of working as this idea was not new to them and they have always worked this way. One of them however made an additional comment saying that if there was an easier way to get funding she or he would use it instead. Two people said that their way of working has changed from an individual approach to adopting the team perspective.

32. Any other factors which supports and impediments have been experienced in building intersectoral collaboration?

A number of factors were mentioned as impediment to the process of intersectoral collaboration: the threshold to meet the HCN criteria was too high and often the funding came too late “like the ambulance at the bottom of the cliff”, a need for a geographically closer “one-stop shop” to have more “seamless interactions between agencies”. Other impediments included past negative experience with high needs cases and with other professionals, constantly changing and complicated procedures to follow, and the number of agencies involved. Other concerns were that the siblings of the HCN youth were not automatically granted the same funding, and a lack of support and resources in the area of mental health. One person expressed that view that informal networking was a more effective way of coloration to because it made better use of time. The same person also said that people were uncomfortable to express their opinion in the meetings; individuals can “hide or go along for a ride in the meeting”. Having previous working relationship and respect for each other were cited as a factor to support the process of intersectoral collaboration.

Table 3 below provides a summary of the individual responses to the interview questions. Over one third of the respondents felt that there was very little support from their agency for collaborative work and over two thirds of them said that there was no support from their colleagues. In addition, all respondents agreed that no formal training was offered to prepare them for collaborative work. Collaborative work was expected but according to two thirds of the respondents, not as part of the performance appraisal criteria. However, over two thirds of the people said that being involved in HCN collaborative cases did not change their role. Over half of the respondents had positive attitudes towards collaborative work and 88% of them said that it was vital to have others' collaboration to do their job well. Two third of the respondents said that they knew each other very well although half of them have never worked with each other in the past. Less than half of the people knew what services other agencies provided.

Table 3

Summary of Individual Responses

| # | Question | Responses | n |
|-----|--|---------------------------|---------|
| 1 | support from own agency | little or no support | 3 (33%) |
| | | encouraged | 1 |
| | | finance | 2 |
| | | very supportive | 2 |
| | | missing data/not answered | 1 |
| 2 | role change | yes | 2 |
| | | no | 6 (67%) |
| | | missing data/not answered | 1 |
| 3 | sufficient time given to do collaborative work | yes | 2 |
| | | no | 5 (55%) |
| | | not applicable | 2 |
| 4 | support from colleagues | yes | 1 |
| | | no | 6 (67%) |
| | | missing data/not answered | 1 |
| | | not applicable | 1 |
| 5 | Training for collaborative work | No | 9 |
| 6. | Collaboration as job appraisal criteria | yes | 2 |
| | | no | 6 (67%) |
| | | missing data/not answered | 1 |
| 7a. | Attitude towards collaboration | Positive | 5 (55%) |
| | | Sceptical | 2 |
| | | missing data/not answered | 1 |
| 7b. | strengths of collaboration | Strengths: | |

| | | |
|--|------------------------------|---------|
| | Commitment | 4 (44%) |
| | Shared resources | 3 (33%) |
| | Coordinator | 2 (22%) |
| | Efficient problem solving | 2 (22%) |
| | Clear communication | 1 |
| Limitations of collaboration | Limitations: | |
| | Process | 3 |
| | Time | 2 |
| | Interpersonal conflicts | 2 |
| | Delay in resources | 2 |
| | Inexperienced coordinator | 1 |
| 8a. familiarity with members | Very well | 6 |
| | Some not that well | 2 |
| | missing data/not answered | 1 |
| 8b. previous working relationship | Never | 4 |
| | More than 40 times | 4 |
| | missing data/not answered | 1 |
| 9. awareness of other agencies' service | Reasonable or good knowledge | 4 |
| | missing data/not answered | 5 |
| 10. importance of others' collaboration to achieve own goals | Vital | 8 |
| | Not applicable | 1 |
| 11. impact of different organisational policies on process | No effect | 5 |
| | Slow the plan down | 3 |
| | Not applicable | 1 |
| 12. Types of conflicts | No conflicts | 3 |
| | Healthy debates | 2 |

| | | |
|------|---------------------------------|---------|
| | Not performing satisfactorily | 2 |
| | People talked too much | 1 |
| | missing data/not answered | 1 |
| 13. | conflict resolution mechanism | |
| | No need | 3 |
| | None in place | 2 |
| | Coordinator to mediate | 2 |
| | Healthy discussion | 1 |
| 14. | Transparency | |
| | No problem | 5 (55%) |
| | Via coordinator | 2 |
| | Not openly spoken | 1 |
| | May cause conflicts | 1 |
| 15. | Support for members | |
| | Regular contact | 3 |
| | not much more | 2 |
| | team support to speed things up | 1 |
| | positive feedback | 1 |
| | acting professional | 1 |
| | give honest opinions | 1 |
| 16. | Existing linkage | |
| | Informal, case by case | 9 |
| 17. | Frequency of contact | |
| | Dependents on client's needs | 9 |
| 18. | Information exchange | |
| | No restrictions | 8 (88%) |
| | Not applicable | 1 |
| 19a. | Meeting effectiveness | |
| | Very effective | 5 |
| | Sometimes | 2 |
| | More so than 1 year ago | 1 |
| | Not productive | 1 |
| 19b. | IST meeting generates more | |
| | Yes | 7 (77%) |

| | | | |
|-----|------------------------------|------------------------------------|---|
| | strategies | No | 1 |
| | | Potentially | 1 |
| 20. | Sharing Responsibility | Clearly defined | 5 |
| | | Volunteers | 3 |
| | | missing data/not answered | 1 |
| 21. | Willingness for lead role | No, too much paperwork | 3 |
| | | Coordinator's job | 3 |
| | | If necessarily | 1 |
| | | Only apply to the three sectors | 1 |
| | | Not applicable | 1 |
| 22. | Influence and decisions | Equal power | 5 |
| | | Legal Guardian decides | 3 |
| | | Coordinator | 1 |
| | | Status, experience & personality | 1 |
| 23. | Ease of reaching agreement | Very easy | 6 |
| | | Majority rule | 1 |
| | | Coordinator decides | 1 |
| | | missing data/not answered | 1 |
| 24. | Contribution of others | Depends on the client's needs | 3 |
| | | Satisfied with others contribution | 5 |
| | | missing data/not answered | 1 |
| 25. | Mechanism for Accountability | Regular meetings & reviews | 4 |
| | | Coordinator to remind | 2 |
| | | No accountability | 1 |
| | | missing data/not answered | 1 |
| 26. | Members' competency | Adequate | 4 |

| | | |
|-----|--|---------------------------------------|
| | Adequate apart from one person | 1 |
| | Commitment more important than competency | 2 |
| | Coordinator's competency is important | 2 |
| 27. | Expectation of outcomes | Optimistic 4 |
| | | 50/50 1 |
| | | up to the young person concerned 3 |
| | | not hopeful 1 |
| 28. | Clarity of outcome measures | Yes 6 |
| | | No 2 |
| | | Difficult to comment 1 |
| 29. | Impact on family | Huge difference 5 |
| | | No difference 2 |
| | | missing data/not answered 2 |
| 30. | Collaboration enhance job satisfaction | Yes 5 |
| | | no 2 |
| | | missing data/not answered 2 |
| 31. | Positive relationship with other agencies | Yes 6 |
| | | No 1 |
| | | Secondary concern 1 |
| | | Not applicable 1 |
| 32. | Collaboration change way of work | No will always work this way 7 |
| | | Yes less individual approach 2 |
| 33. | Other support & impediments experienced in collaborative process | Criteria too strict 2 |
| | | More seamless service interactions 1 |
| | | Past negative experience with other 1 |

| | |
|-----------------------------------|---|
| agencies | 2 |
| Ever-changing & complex procedure | 1 |
| Siblings not granted funding | 1 |
| automatically | |
| Informal network more effective | |

Observations of meeting

A total of six meetings were observed including two meetings of each team.

Team “Sam”. There were 7 professional members of the team “Sam”. The average meeting duration was 56 minutes (see Table 3). Six members were present for the first meeting so data were collected on all of them and the random number process was not used. Two members attended the second meeting. On average 57% of the professional members attended the meeting. Two professional members attended both meetings which accounted for 29% of the full professional team attended both meetings. A total of 333 comments (260 for meeting 1, 73 for meeting 2) were recorded. On average, suggesting Goals and Strategies was the most frequent activity of Team “Sam” which generated 75 comments (54 for meeting 1; 21 for meeting 2). This was followed by Seeking Information which generated 67 comments (39 for meeting 1; 28 for meeting 2). Feedback about the Goals generated 64 comments (55 for meeting 1; 9 for meeting 2). Providing Information generated 49 comments (35 for meeting 1; 14 for meeting 2). Decisions and Responsibilities generated 32 comments (32 for meeting 1; none for meeting 2). Positive Group Participation generated 10 comments (10 for meeting 1; none for meeting 2). Negative Group Participation generated 3 comments (3 for meeting 1; none for meeting 2). Non-Verbal Behaviour generated 0 behaviours. Distraction generated 15 comments (14 for meeting 1; 1 for meeting 2). Others generated 18 comments (18 for meeting 1; none for meeting 2).

The number of statements per category was summed across participants for each meeting. Percentages were calculated by dividing the number of statements recorded for each category by the total number of statements recorded. Group Participation was further categorised into positive (soliciting contributions from other team members) and negative group participation (discouraging others from

participating). Total positive meeting behaviour therefore included providing information, seeking information, goals/strategies, feedback about goals, decision/responsibility, and positive group participation. Total negative meeting behaviour therefore included negative group participation, unpunctuality and distracting behaviour.

From Meeting 1 to Meeting 2, there was an increase of comments of Providing Information from 13% to 19%, Seeking Information from 15% to 38%, Goals and Strategies from 21% to 29%. Comments on Feedback about Goals decreased from 21% to 12% from meeting 1 to meeting 2, Decision/Responsibility from 12% to 0%, Group Participation from 5% to 0%, Non-verbal Behaviour from 5% to 1%, and Others from 7% to 0%. (See Fig. 1). Total positive meeting behaviour increased from meeting 1 (87%) to meeting 2 (99%) and total negative meeting behaviour decreased from meeting 1 (7%) to meeting 2 (1%). Total time spent on positive, negative meeting behaviours and other were 93%, 4% and 3% respectively (See Fig. 2).

Table 4.

Team "Sam": Percentage of Total Activities Observed for Meeting 1 and Meeting 2

| | Meeting 1 | Meeting 2 | total | Average across meetings |
|-------------------------|------------|------------|-------|-------------------------------|
| Attendance | n=6 (86%) | n=2 (29%) | - | 57% |
| Meeting Duration | 62 minutes | 50 minutes | - | 56 minutes |
| Providing Information | 35 (13%) | 14 (19%) | 49 | 16% |
| Seeking Information | 39 (15%) | 28 (38%) | 67 | 27% |
| Goals/Strategies | 54 (21%) | 21 (29%) | 75 | 25% |
| Feedback about Goals | 55 (21%) | 9 (12%) | 64 | 17% |
| Decision/Responsibility | 32 (12%) | 0 (0%) | 32 | 6% |
| Positive Group | | | 10 | |
| Participation | 10 (4%) | 0 (0%) | | 2% |
| TOTAL POSITIVE | 225 (87%) | 72 (99%) | 297 | 93% |
| Negative Group | | | 3 | |
| Participation | 3 (1%) | 0 (0%) | | 2% |
| Distraction | 14 (5%) | 1(1%) | 15 | 3% |
| Non-verbal behaviour | 0 | 0 (0%) | 0 | 0% |
| TOTAL NEGATIVE | 17 (7%) | 1 (1%) | 18 | 4% |
| Others | 18 (7%) | 0 (0%) | 18 | 3% |
| Total | 260 (100%) | 73 (100%) | 333 | - |

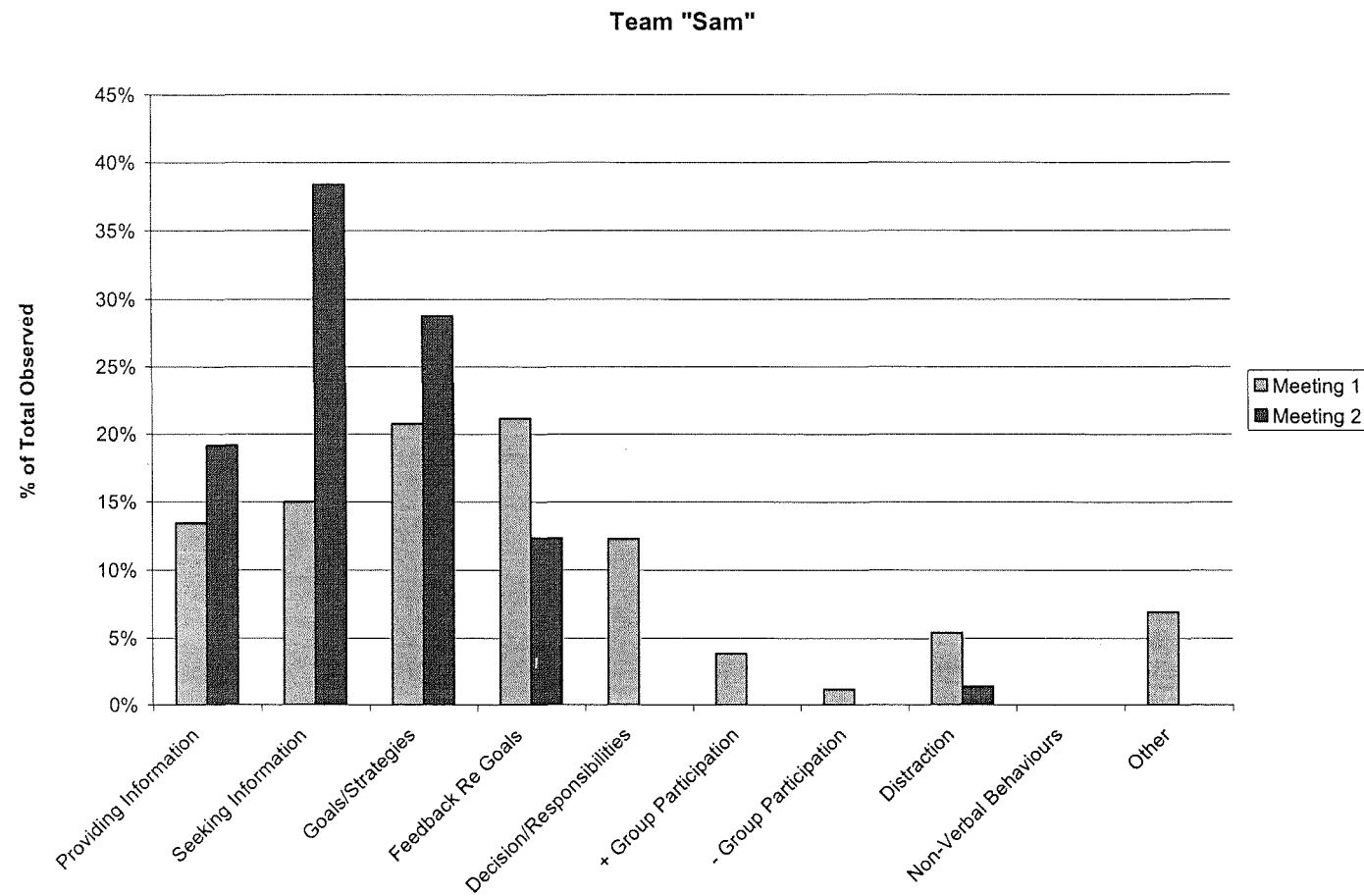


Figure. 1. Team "Sam": changes of percentages from meeting 1 and meeting 2

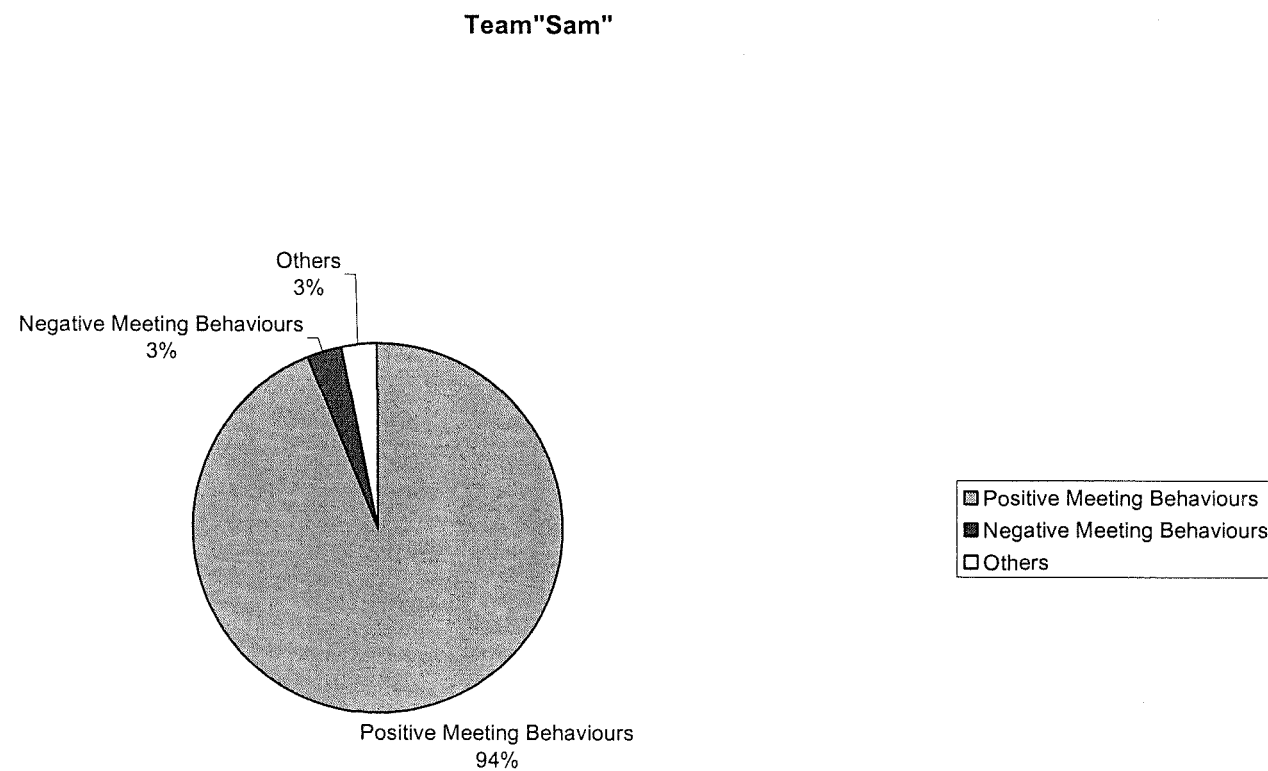


Figure 2. Team Sam: percentage time spent on positive meeting behaviours, negative meeting behaviours and others.

Team “Chris”. There were 7 professional members of team “Chris” and all 7 members were present for both meetings. Therefore there was 100% attendance of the full team at each meeting. The average meeting duration was 68 minutes (see Table 4). For Team “Chris”, a total of 400 comments (173 for meeting 1, 227 for meeting 2) were recorded for both meetings. Suggesting Goals and Strategies was the most frequent activity of Team “Chris” which generated 108 comments (44 for meeting 1; 64 for meeting 2). This was followed by Providing Information which generated 83 comments (40 for meeting 1; 43 for meeting 2). Feedback about the Goals generated 70 comments (36 for meeting 1; 34 for meeting 2). Seeking Information generated 67 comments (33 for meeting 1; 34 for meeting 2). Decisions and Responsibilities generated 15 comments (1 for meeting 1; 15 for meeting 2). Positive Group Participation generated 18 comments (12 for meeting 1; 6 for meeting 2). Negative Group Participation generated 3 comments (none for meeting 1; 3 for meeting 2). Distraction generated 3 comments (3 for meeting 1; none for meeting 2). Non-Verbal Behaviour generated 1 behaviours (none for meeting 1; 1 for meeting 2). Others generated 32 comments (6 for meeting 1; 26 for meeting 2).

Again, percentages were calculated by dividing the number of statements recorded for each category by the total number of statements recorded. From Meeting 1 to Meeting 2, there was an increased comments of Goals and Strategies from 25% to 28%, Decision/Responsibility from 1% to 6%, and Others from 3% to 11%. Comments on Providing Information was decreased from 23% (meeting 1) to 19% (meeting 2), Seeking Information from 19% to 15%, Feedback about Goals from 21% to 15%, Group Participation from 7% to 4%. Non-verbal Behaviour remained unchanged. (Changes are

shown in Fig. 3). Total time spent on positive, negative meeting behaviours and other were 91%, 2% and 7% respectively (see Fig. 4).

Table 5

Team "Chris": Percentage of Total Activities Observed for Meeting 1 and Meeting 2

| | Meeting 1 | Meeting 2 | Total | Average across meetings |
|-------------------------|------------|------------|-------|-------------------------------|
| attendance | n=7 (100%) | n=7(100%) | - | 100% |
| Meeting Duration | 60 minutes | 75 minutes | - | 68 minutes |
| Providing Information | 40(23%) | 43(19%) | 83 | 21% |
| Seeking Information | 33(19%) | 34(15%) | 67 | 17% |
| Goals/Strategies | 44(25%) | 64(28%) | 108 | 27% |
| Feedback about goals | 36(21%) | 34(15%) | 70 | 18% |
| Decision/Responsibility | 1(1%) | 14(6%) | 15 | 4% |
| Positive Group | | | 18 | |
| Participation | 12 (7%) | 6 (3%) | | 5% |
| TOTAL POSITIVE | 166 (95%) | 195 (87%) | 361 | 91% |
| Negative Group | | | 3 | |
| Participation | 0 (0%) | 3 (1%) | | 1% |
| Distraction | 3 (2%) | 0 (0%) | 3 | 1% |
| Non-verbal behaviour | 0 (0%) | 1 (0%) | 1 | 0% |
| TOTAL NEGATIVE | 1 (1%) | 6 (3%) | 7 | 2% |
| Others | 26(3%) | 26(11%) | 32 | 7% |
| Total | 173 (100%) | 227 (100%) | 400 | |

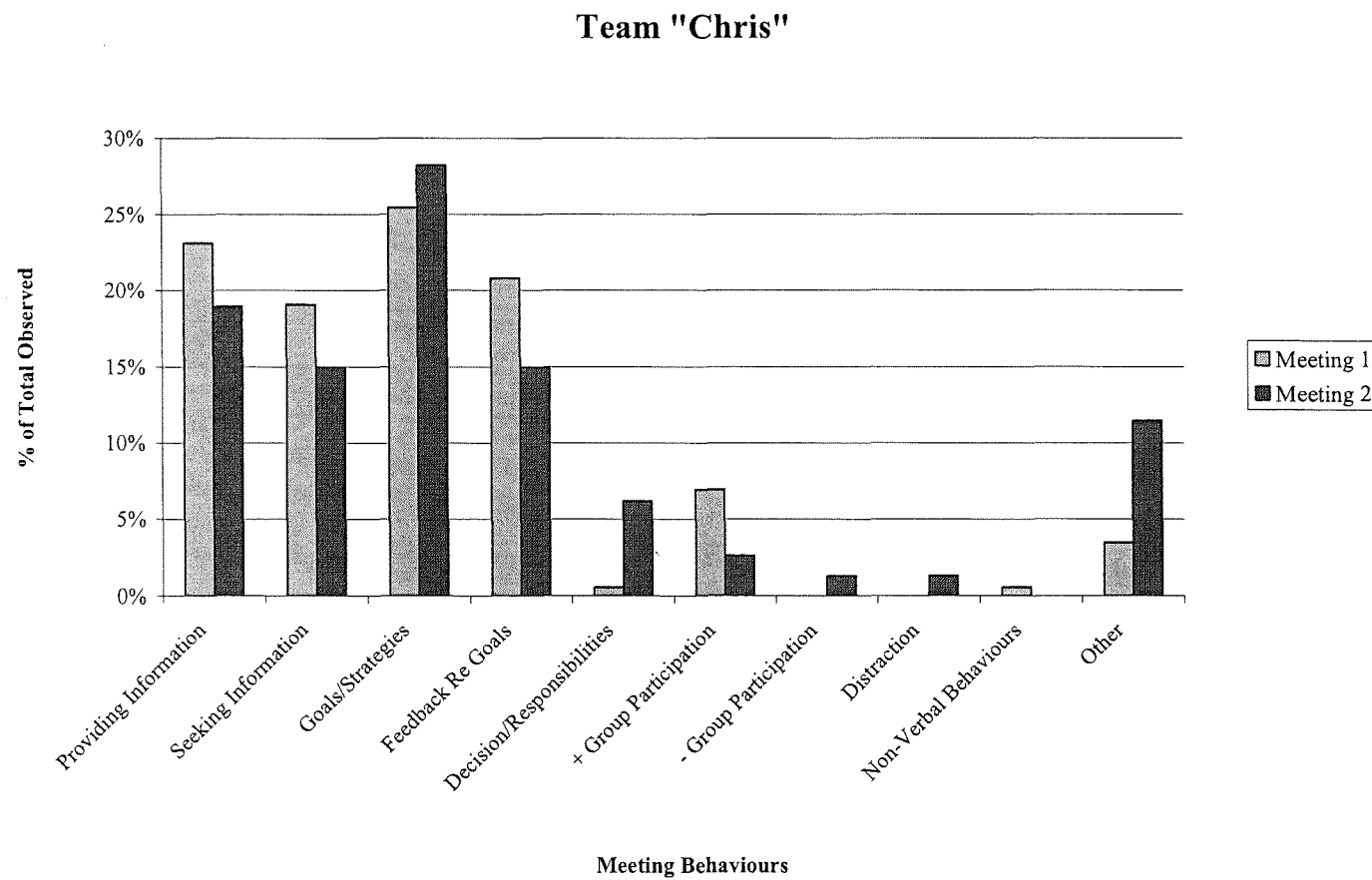


Figure. 3. Team "Chris": changes of percentages from meeting 1 and meeting 2

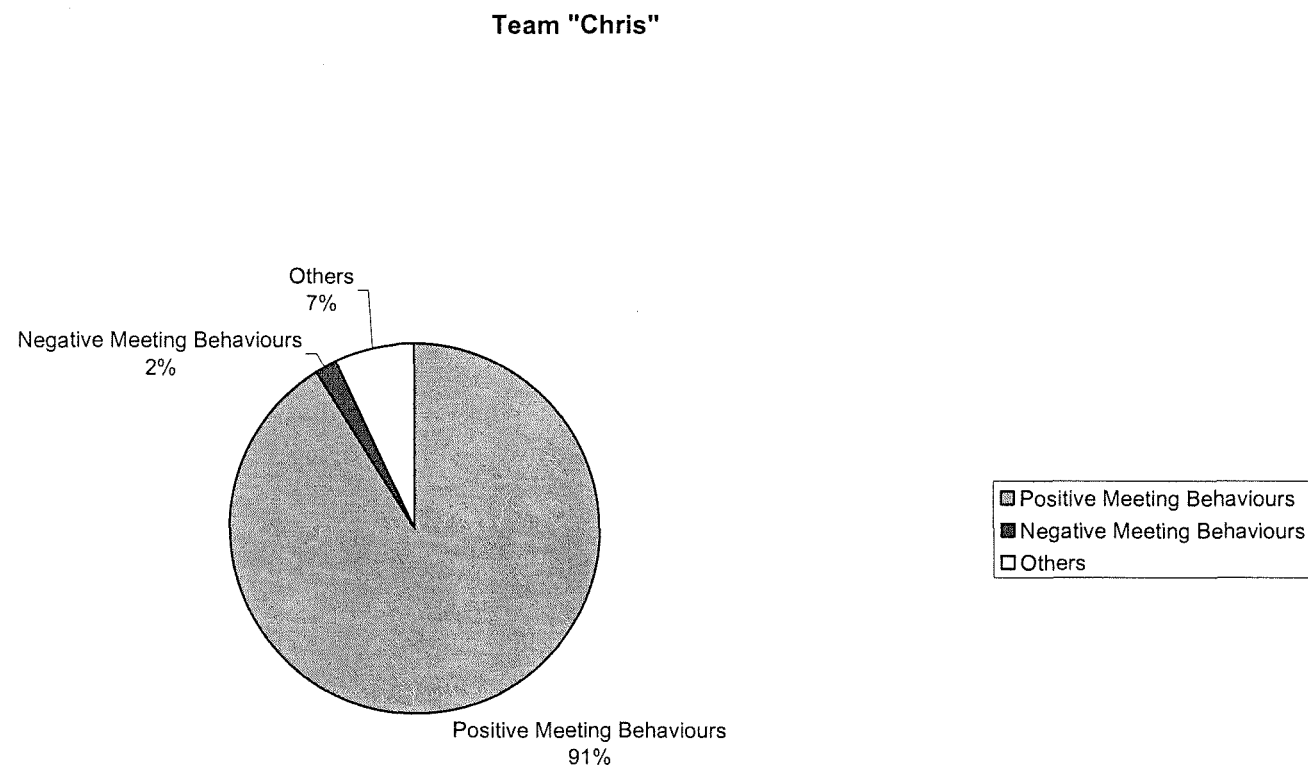


Figure. 4. Team Chris: percentage time spent on positive meeting behaviours, negative meeting behaviours and others.

Team “Alex”. There were 8 professional members of Team “Alex”. There were 7 members who attended the first meeting and all 8 were present for the second meeting. Hence on average 94% of the members turned up for meetings. Seven members (which accounts for 88% of the full team) attended both meetings. The average meeting duration was 75 minutes (See Table 5). For Team “Alex”, a total of 260 comments (99 for meeting 1, 161 for meeting 2) were recorded for both meetings. Suggesting Goals and Strategies was the most frequent activity of Team “Alex” which generated 64 comments (30 for meeting 1; 34 for meeting 2). This was followed by Providing Information which generated 58 comments (16 for meeting 1; 42 for meeting 2). Others generated 40 comments (16 for meeting 1; 24 for meeting 2). Seeking Information generated 32 comments (8 for meeting 1; 24 for meeting 2). Feedback about the Goals generated 28 comments (9 for meeting 1; 19 for meeting 2). Decisions and Responsibilities generated 24 comments (14 for meeting 1; 10 for meeting 2). Positive Group Participation generated 9 comments (3 for meeting 1; 6 for meeting 2). Negative Group Participation generated 3 comments (1 for meeting 1; 2 for meeting 2). Non-Verbal Behaviour generated 0 behaviours. Distraction generated 2 comments (2 for meeting 1; none for meeting 2).

From Meeting 1 to Meeting 2, there was an increased comments of Feedback about Goals from 9% to 12%, Seeking Information from 8% to 15%, Providing Information from 16% to 26 %, Group Participation from 4% to 5%. Comments on Goals and Strategies were decreased from 30% to 21%, on Decision/Responsibility from 14% to 6%, on Non-verbal Behaviour from 2% to none, and Others from 16% to 15%.

Changes from Meeting 1 to Meeting 2 are shown in Fig. 5. Total time spent on positive, negative meeting behaviours and other were 82%, 2% and 16% respectively (see Fig. 6).

Table 6

Team "Alex": Percentage of Total Activities Observed for Meeting 1 and Meeting 2

| | Meeting 1 | Meeting 2 | total | Average across meetings |
|-------------------------|------------|------------|-------|-------------------------------|
| Attendance | n=7 (88%) | n=8 (100%) | - | 94% |
| Meeting duration | 41 minutes | 68 minutes | - | 75 minutes |
| Providing Information | 16(16%) | 42(26%) | 58 | 21% |
| Seeking Information | 8(8%) | 24(15%) | 32 | 11% |
| Goals/Strategies | 30(30%) | 34(21%) | 64 | 26% |
| Feedback about goals | 9(9%) | 19(12%) | 28 | 10% |
| Decision/Responsibility | 14(14%) | 10(6%) | 24 | 10% |
| Positive Group | | | 9 | |
| Participation | 3 (3%) | 6 (4%) | | 3% |
| TOTAL POSITIVE | 80 (81%) | 135 (84%) | 215 | 82% |
| Negative Group | | | 3 | |
| Participation | 1 (1%) | 2 (1%) | | 1% |
| Distraction | 2 (2%) | 0 (0%) | 2 | 1% |
| Non-verbal behaviour | 0 (0%) | 0 (0%) | 0 | 0% |
| TOTAL NEGATIVE | 3 (3%) | 2 (1%) | 5 | 2% |
| Others | 16(16%) | 24(15%) | 40 | 16% |
| total | 99 (100%) | 161 | 260 | |

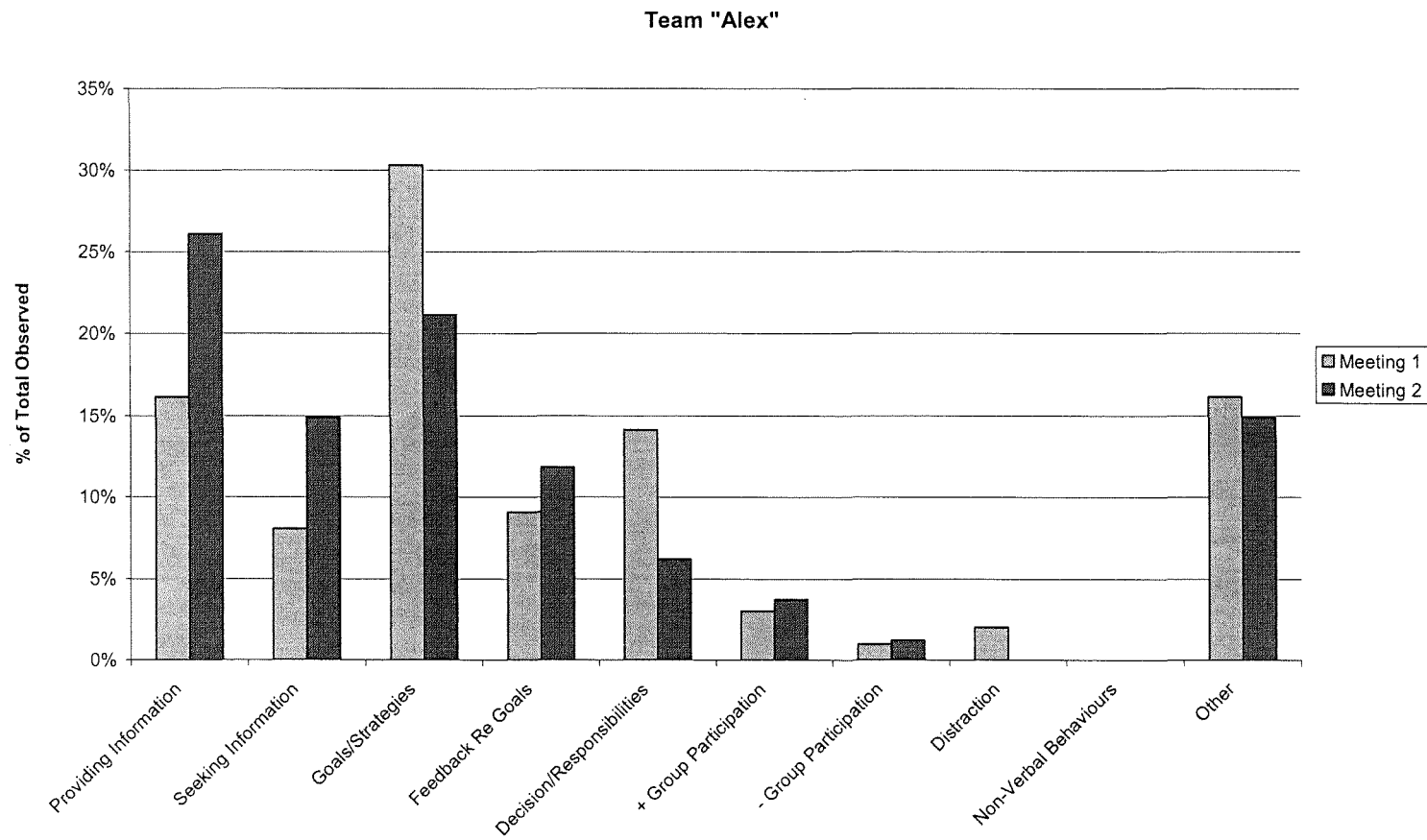


Figure. 5. Team "Alex": changes of percentages from meeting 1 and meeting 2

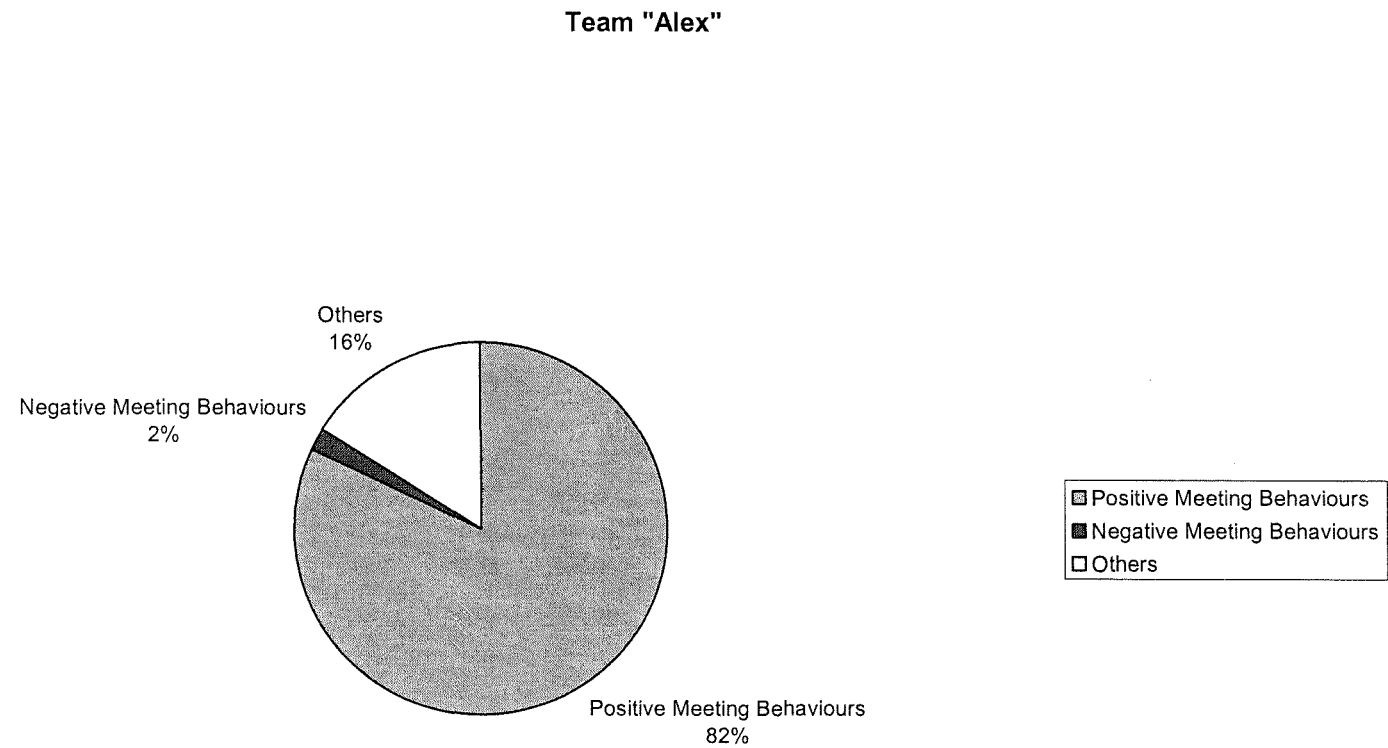


Figure 6. Team Alex: Percentage time spent on positive meeting behaviours, negative meeting behaviours and others.

Results of the three teams' meeting behaviours are as summarized in Table 7 and 8 below. The meeting duration was approximately the same for all three teams from 56 to 68 minutes, with Team "Chris" had longest average meeting duration of 68 minutes. Team "Chris" had the highest attendance rate (all members present at meetings), while just over half of the members of Team "Sam" attended the meetings. While Team "Sam" had the smallest number of people at the meeting, it had highest total number of comments (167) made during the meeting, which was more than twice as many as that of Team "Chris" which had full team present. Team Alex made more comments (20) on topics which were categorized as "others". All three teams spent over one quarter of the time suggesting goals and strategies. All three teams spent just under half of their time in proposing and discussing goals and strategies. It would be expected that the larger team would spend longer time on updating each other about the client's current situation, Team "Chris" spent the first 25 minutes of the meeting on providing and seeking information while it took 14 minutes for Team Sam. Time spent on making decisions and distributing responsibilities were all less than 6 minutes for all three teams.

Table 7*Average Number of Observed Team-Related Behaviours*

| Meeting Behaviours | Sam | Chris | Alex |
|-------------------------|------------|------------|------------|
| Meeting Duration | 56 minutes | 68 minutes | 55 minutes |
| Attendance Rate | 57% | 100% | 94% |
| Providing Information | 25 | 42 | 29 |
| Seeking Information | 34 | 34 | 16 |
| Goals/Strategies | 38 | 54 | 32 |
| Feedback about goals | 32 | 35 | 14 |
| Decision/Responsibility | 16 | 8 | 12 |
| Positive Group | 5 | 9 | |
| Participation | | | 5 |
| TOTAL POSITIVE | 149 | 181 | 108 |
| Negative Group | 2 | 2 | |
| Participation | | | 2 |
| Distraction | 8 | 2 | 1 |
| Non-verbal behaviour | 0 | 1 | 0 |
| TOTAL NEGATIVE | 9 | 4 | 3 |
| Others | 9 | 16 | 20 |
| Total | 167 | 75 | 130 |

Table 8.

Average Proportion of Time Spent on Aspects of Team Process during Meetings

| Aspects of Team | Sam | Chris | Alex |
|-------------------------|------------------|------------------|------------------|
| Process | | | |
| Meeting Duration | 56 minutes | 68 minutes | 55 minutes |
| Providing Information | 16% (9 minutes) | 21% (14 minutes) | 21% (12minutes) |
| Seeking Information | 27% (5 minutes) | 17%(12 minutes) | 11% (6 minutes) |
| Goals/Strategies | 25% (14 minutes) | 27%(18 minutes) | 26% (14 minutes) |
| Feedback about goals | 17% (9 minutes) | 18% (12 minutes) | 10% (6 minutes) |
| Decision/Responsibility | 6% (3 minutes) | 4% (2 minutes) | 10% (6 minutes) |
| Positive Group | | | |
| Participation | 2% (1 minute) | 5% (3 minutes) | 3% (2 minutes) |
| TOTAL POSITIVE | 93% (52 minutes) | 91% (62 minutes) | 82% (45 minutes) |
| Negative Group | | | |
| Participation | 1% (1 minute) | 1% (< 1minute) | 1% (1 minute) |
| Distraction | 3% (2 minutes) | 1% (< 1 minute) | 1% (1 minute) |
| Non-verbal behaviour | 0% | 0% | 0% |
| TOTAL NEGATIVE | 4% (2 minutes) | 2% (1 minute) | 2% (1 minute) |
| Others | 3% (2 minutes) | 7% (5 minutes) | 16% (9 minutes) |
| Total | 100% | 100% | 100% |

Chapter 5

Discussion

This study described some aspects of the team process of the three ISTs in the High and Complex Needs Unit in New Zealand and the particular issues as perceived by 9 IST members. Three ISTs from HCN were observed: Team “Sam”, Team “Chris” and Team “Alex”.

Interpretation

On average, the three teams spent similar percentages of time on various team processes. Team “Sam” had a particularly high percentage on seeking information during meeting 2. This was because a crisis occurred between the meetings and it took some time to bring members up to date with this latest development. Team “Sam” also had high percentage of distractions because the majority of members arrived late when the meeting was called on short noticed and the location of the meeting was unfamiliar at a new meeting location. Team “Alex” had a much higher percentages of time on the “other” category than the other two teams. A closer examination of data revealed that the majority of these comments were positive feedback and appreciation between members. There appeared to be a high satisfaction amongst members as the plan for “Alex” was going well according to “Alex” and the family members.

For each team, different patterns of changes occurred between meeting 1 and meeting 2. The observed changes of various team processes appeared to be related to the stage of plan development. For instance, Team “Alex” was at the end of the plan and the

plan was working smoothly; therefore a decrease of new goals and strategies, as well as a decrease of decisions and responsibilities associated with the goals and strategies would be expected. The data from the meeting observations confirmed precisely these changes. Team “Chris”, however, was re-evaluating its plan to address aspects which needed changes. Therefore there was an increased time spent on generating alternative solutions and making new decisions.

It was noted that very few negative meeting behaviours were observed for all three teams. The total negative meeting behaviour accounted for only 2% to 3% of the meetings. This may be due to a number of factors that members reported in the interviews. For instance, members generally had good interpersonal relationships and were satisfied with others’ commitment and contribution. In addition, there did not appear to have any open conflicts and the majority of them said that it was very easy to reach agreement. This suggested that all three teams had a good awareness of the team process and were professional in their ways of relating to each other during the meetings.

Members’ responses to the interview questions were generally confirmed by the meeting observations. For instance, most members said that they had a positive attitude towards collaboration. This was reflected by fact that very few negative meeting behaviours were observed during IST meetings. Further, members responded that it was easy to come to an agreement about the plan and their responsibilities were clearly defined. This was consistent with the observation that most teams spent only two to three minutes on decision-making and allocating responsibility.

The team size varied between seven to eight members and the meeting duration of the three IST teams was approximately an hour. This was consistent with the literature

which reported meeting length varying between 30 to 60 minutes (Lamorey & Ryan, 1999; Goldstein et al., 1980; Ysseldyke et al., 1982, & Ysseldyke et al., 1982). One problem reported by Huebner and Gould, (1991), Radcliffe and Hegarty (2001), and Hinojosa, et al., (2001) was that the full team was not present at the meeting. To avoid this problem, attendance is mandatory in the HCN process and therefore a 100% attendance rate was expected. The results showed that Team “Chris” had a full team present for both meetings and everyone except one person missed one of the meetings for Team “Alex”. Team “Sam”, however, had a particularly low attendance for its second meeting. Only two members out of a team of seven people attended the meeting. This was because a crisis occurred the day before the meeting and not all members were aware of the meeting because of the very short notice of time.

Regarding the percentage of various team processes, it was found that the IST teams spent over one third of the meeting in providing and seeking information. An IST meeting usually begins with a procedure by going around each member reporting any new development and progress since the last meeting. Any concerns or problems are also brought up during the round. Despite the differences in team sizes, similar percentage of time spent on providing and seeking information were reported by Goldstein (1980) and Ysseldyke (1982). Therefore it appeared that such procedure of going around did not necessarily take up more time. In fact, such procedure allows each member an equal opportunity to contribute, particularly for those who may not be as assertive and verbal as some others.

Contrary to the findings of Bailey (1982) and Goldstein (1980), a very high percentage of time (ranging from 36% to 45%) was spent on discussing goals and

strategies for all three ISTs. After updating the team about the current needs of the client, it is important that the team devotes sufficient amount of time in setting new goals and future steps to take in order to achieve these goals. In fact, prioritisation of goals and strategies is identified as a positive factor for team process. As team members exploring options for services, they are engaged in the process of problem solving as a team. An effective meeting is in general task focused instead of problem focused (Nichols et al., 2002; Walker & Schutte, 2005). When it is clear that the objective of the meeting is to make changes in the client's life in general, some changes must take effect as a result of the meeting. Therefore suggestions and strategies to make these changes happen is an important mean to an end. The results of this study suggested that effective team processes were in place during the IST meetings; the teams devoted more than one third of the meeting time to obtain an accurate understanding of the clients' needs and then 20 to 30 minutes within the hour was used to generate steps to meet the needs of the clients.

On average, ISTs spend a greater percentage of time on making decisions and distributing responsibility than that reported by Goldstein et al. (1980) by about 5%. The decision-making process was expected to take longer, as IST dealt with individuals with high needs while only the educational needs were discussed during IEP meetings in the study by Goldstein et al. (1980).

Several issues regarding HCN were highlighted as a result of the interviews. Although collaboration was generally encouraged by agencies, there was no additional time allocated for attending meetings and tackling extra paperwork during the HCN process. This meant that members had to make time to for collaborative teamwork. No practical support was available from their colleagues since everyone had heavy caseloads.

Therefore being involved in collaborative teamwork actually increased the workload, which may prevent some people from being involved in a HCN team approach. The amount of bureaucracy required in HCN process was identified as the greatest barrier to collaboration. Several members stressed that the process was daunting, complicated and changed too frequently. This may result in members avoiding using the HCN process and not taking advantage of the resources available in order to help their clients. However, once the initial hurdle of setting up was crossed, there were more benefits than limitations from working collaboratively. Over half of the members interviewed said that the IST meetings were effective in generating more strategies and they were optimistic about the outcomes. Although the outcomes depended ultimately on the clients' willingness to change, the professionals felt that their clients were given the best chance to make a difference for themselves because of the amount of resources and joint effort IST members put in. In addition, members said that collaboration increased their job satisfaction and enhanced the positive relationships they have with other agencies. It would appear that the greatest benefit came from the fact that IST members were able to help their clients effectively when all previous efforts had failed. From the members' perspective, the HCN team approach was a viable strategy when dealing with this group of clients with very high and complex needs.

The benefits of collaborations identified in this study were consistent with the literature. They included shared resources, commitment, clear communication and effective leadership (Lamorey & Ryan, 1998). It was noted that although lack of training on team process was not specifically mentioned as a problem, none of the agencies offered any training to IST members to prepare them for collaborative work. Further

collaboration was not included in the performance review criteria. It would appear that it was taken for granted that members would collaborate with others and there was a lack of appreciation of the role of team process in relation to outcomes. Nichols et al. (2002) believed that many organizations devalue team process because it takes too much time to develop and maintain a team. While most agencies had a long waiting list, the emphasis was on productivity rather than quality of results. Agreeing with the results from the Strengthening Families survey in New Zealand (Visser, 2000), IST members confirmed that they had always worked in collaboration with others and HCN simply formalized their way of working. Some of the problems identified in the literature did not appear to be limitations for IST members; for instance, funding limitations, clarity of roles, transparency, accountability, status and influence (Pfeiffer, 1981; Frankenberger & Harper, 1988; Huebner & Gould, 1991; Hinojosa et al., 2001; Malone & Mcpherson, 2004; www.hcn.govt.nz, no date). This may be because the HCN protocol specifies each member's responsibility, mandates the sharing of information, has a regular review mechanism in place, and assigns a coordinator to follow HCN meeting procedures and administrative duties.

Conclusions

Most members perceived that HCN team approach was far more effective in caring for children and young people with high and complex needs, than managed alone by any single agency. IST members had positive beliefs about multidisciplinary, intersectoral team approach. Table 1 summarising the literature review highlighted the

significant facilitators and barriers to collaboration: the results of the observation and interviews in this study confirm that these are significant facilitators and barriers.

Strengths

There are several strengths of the present study. The first strength is the use of empirically validated instruments for both the semi-structured interview and the meeting observations. The interview questions have sound theoretical basis based on the Interagency Collaboration Model by Polivka (1995) and they were reviewed and considered appropriate in the HCN context by the HCN Plan Advisor. The instrument used to measure meeting behaviours is adapted from that used by Bailey & Helsel-DeWert (1981) which has good reliability and validity. A further strength of this study is that the data were recorded as frequency tally instead of being transformed into ratings as suggested in Bailey & Helsel-DeWert (1981). Because the data used in this study is not manipulated into subjective ratings, it gives a more accurate and objective pictures of the meeting behaviours. Another strength of the current study is that the data is analysed and presented as both percentages and minutes, which provides a fuller understanding of the team meeting behaviour within the context of the meeting duration.

Limitations

The current study also has several methodological issues. First, there was only one observer present at the meetings so that the inter-observer reliability could not be established. Secondly, due to the scope of this study, a very small sample of participants was used and therefore the generalisability of the study results is very limited. The third

limitation is that data collected during the second meeting of Team “Sam” may not capture members’ typical behaviour because of the recent crisis.

Implications for Practice

Many of the problems identified in the literature appeared to be related to team structures. They included financial constraints, lack of effective meeting procedures, roles confusion, poor leadership and lack of planned evaluation. A highly formalised process such as HCN seemed to greatly reduce these problems because the protocol specified clearly the expectations and procedures of collaboration. Unfortunately one disadvantage of the process was the over-complicated bureaucracy involved. It may be that the process could be simplified by reviewing the decision-making powers at local, regional and national levels. Also there is a discrepancy between the level of support advocated by the government policy and the actual level within the organisations. Despite the fact that collaboration was supported at the national level as shown by the policy and unlimited funding of the HCN process, staff were overworked within the agencies and there was no time devoted to the development or the training of collaborative work according to the literature. This finding has two important implications. First, there seems to be a lack of appreciation of the importance of team process and it is taken for granted that staff have the knowledge and the skills in participating in collaborative teamwork. While the agency encourages its staff to collaborate with other agencies, there are no practical incentives offered for those who do such as support for workload or inclusion of collaboration as job appraisal criteria. More education on the role of team process and support to the field staff is needed in order to truly encourage interagency collaboration.

As stated earlier, there is discrepancy between what the government advocates and the resources available within the organisations to meet these expectations. This may be a result of insufficient consultation during the process of policy-making and the deficiency in the feedback loop to the central government. Therefore the second implication is that the government policy needed to take into account the practical limitation of the agencies and address these areas on an organisational level.

Improvement in communication between government and agencies is needed in order to facilitate understandings of the practical concerns facing field staff and the local agencies.

Implications for Future Research

There is a clear need for further research in the field of MDT. First, there has been little empirical research using objective data collection methods in general and particularly in the New Zealand context. Future research should continue to study team process by increasing the sample size in order to improve the generalisability. As the team process may change under different environmental influences, other research could compare the team behaviour within different structures and set up. This may lead to further insight of the impact of contextual factors on the team process. The interview results pointed to the HCN process as the greatest barrier to collaboration, future research may explore ways of simplifying the HCN process. As the results suggest that more education on the role of team process is needed on an organisational level, more research could look into discovering ways for agencies to incorporate training in collaboration in to their staff professional development.

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Appendix 1.

Letter of Approval from the Human Ethics Committee

Ref: HEC 2005/55

8 July 2005

Ming Fei Chung
Education Department
UNIVERSITY OF CANTERBURY

Dear Ming Fei

The Human Ethics Committee advises that your research proposal “**Case Studies of inter-disciplinary team practices for children with high and complex needs in Aotearoa New Zealand**” has been considered and approved.

Yours sincerely

Dr Catherine Moran
Interim Chair

Appendix 2.
Information Sheet



Case Studies Of Inter-Sectoral Team Practices For Children With
High And Complex Needs In Aotearoa New Zealand:
A Research Dissertation

INFORMATION SHEET

My name is Fei Chung and I am a student of the Child and Family Psychology Programme at the University of Canterbury which prepares people as registered psychologists to work in the area of child and family psychology. I am currently researching the intersectoral team practices in New Zealand for my dissertation towards my Master of Education degree. I would be grateful if you would agree to participate as a subject in the research project: *Case studies of intersectoral team practices for children and young people with high and complex needs in Aotearoa New Zealand*. This research proposal has been developed and will be co-supervised by Dr. Barry Newcombe.

The aim of this project is to explore the intersectoral practices of intervention in the New Zealand context and relate observed New Zealand intersectoral practices to international literature. It is hoped that the results from these case studies will contribute to our understanding of the intersectoral team practices and stimulate further research interests; ultimately promote quality of service delivery to children, young people and their families in New Zealand.

Your involvement in this project will involve a one hour semi-structured interview and being observed at intersectoral team meetings that you currently attend convened by a Local Services Coordinator for a young person with high and complex needs. The results of the project may be published, but you may be assured of the complete confidentiality of data gathered in this investigation: your identity and the identity of your agency will be kept confidential and protected. Statistical summaries and anonymous quotations will be presented in the report. To ensure anonymity and confidentiality, any written information will be stored on the researcher's computer with password protection or in the lockable cabinet. Data with identifying detail removed is accessible to the project

supervisors Consent forms with identifying detail and code numbers will be shredded once the dissertation is submitted and accepted. Statistical summaries of the data, and anonymous quotations may be incorporated in a publication(s) arising from the project, in addition to the dissertation. Verbal consent will be obtained from all meeting participants present to observe the intersectoral meetings. However, meeting participants will not know whether a particular individual consented to participate in the study or not. Only those consenting will have their participation recorded during the meetings.

The research dissertation is being carried out as a requirement for Master of Education (Child and Family Psychology) by Fei Chung under the supervision of Dr. Kathleen Liberty (School of Education and Health Sciences Centre, University of Canterbury) and co-supervised by Dr. Barry Newcombe. Dr. Liberty can be contacted at 364-2545 and Dr. Newcombe at 332-0317. They will be pleased to discuss any concerns you may have about participation in the project. I can be contacted on 0211628252.

The project has been reviewed and approved by the University of Canterbury Human Ethics Committee.

Appendix 3.
Consent Form

Fei Chung
23a Prestons Road
Redwood
CHRISTCHURCH

March 10, 2006

Case Studies Of Inter-Sectoral Team Practices For
Children With High And Complex Needs In Aotearoa New
Zealand:

A Research Dissertation

CONSENT FORM

Project: Case studies of intersectoral team practices for children and young people with high and complex needs in Aotearoa New Zealand.

I consent to being interviewed with the right to read and correct the written notes of the interviewer. I know my name or identifying information will not be used in the report

Yes{ } No{ }

I consent to being observed at intersectoral meetings with the right to look at data collected and make corrections at a time to be arranged.

Yes{ } No{ }

I have read and understood the description of the above-named project. On this basis I agree to participate as a subject in the project, and I consent to publication of the results of the project with the understanding that anonymity will be preserved. I understand also that I may at any time withdraw from the project, including withdrawal of any information I have provided.

NAME (please print):

Signature: Date:

Contact Details to arrange interview

Appendix 4.
Interview Questions



Case Studies in Inter-sectoral Team Practices for Children with High and Complex Needs in Aotearoa New Zealand: A Research Dissertation

INTERVIEW QUESTIONS

Fei Chung

June 2005

Questionnaire prepared for a dissertation
in partial fulfilment of the requirements for the degree of
M.Ed. (Child and Family Psychology)

Child and Family Psychology Programme, School of Education
University of Canterbury
Christchurch New Zealand



INTERVIEW QUESTIONS: Case studies of inter-sectoral team practices for children with high and complex needs in Aotearoa New Zealand

Fei Chung, Child and Family Psychology Programme, School of Education, University of Canterbury

Demographic Information of Intersectoral Team Member

| | | |
|--------------|----------------|-----------|
| Gender | M | F |
| Ethnic Group | NZ Maori | Niuean |
| | NZ European | Samoan |
| | Other European | Chinese |
| | Tongan | Tokelauan |
| | Indian | Other |

Education/Qualifications

Name of Agency

General Goals of Agency

Job Title

Years at agency

Years of intersectoral experience

Date interviewed

1. How well does your agency support local collaborative efforts?

What is your current role in the agency?

2. Does being involved in IST change your role?

If so, how? If not, why not?

3. Does your line manager give you sufficient time to take part in intersectoral work?

4. Do your work colleagues support your involvement in IST?

What are the incentives and barriers to your role expansion?

What are ways to reduce barriers to role expansion

5. What kinds of training are available to prepare staff for collaboration work within the organisation?

To what degree is the collaboration (info sharing, relationship building) part of your performance assessment criteria?

6. Please comment on the willingness and interest of your manager/colleagues for cases (intersectoral collaboration) like this in the future.

7. What is your attitude/belief towards intersectoral collaboration?

What are your views on the strengths and limitations of intersectoral collaboration approach?

8. How well do you know the other members from other sectors?

By first name?

How many times have you worked together in the past?

9. How well do you know the specific services of the other sectors?

Are there common elements in the services they provide?

10. How important is intersectoral collaboration to the achievement of your agency's goals?

11. How do the differences between agencies' priorities and policies affect the intersectoral collaboration process?

12. What are the types of conflicts (if any) you have noticed during IST meetings?

13. What kind of processes are in place for recognising and resolving conflict in the IST meetings? (e.g. patch protection/attitude towards collaboration)

14. How is information sharing, openness and transparency achieved at IST?

15. In what ways can members support each other informally/formally?

16. What are the existing linkages between agencies (sectors)?

17. How often do you contact other IST members?

18. To what degree do you exchange information with other sectors?

Do you/your agency refer clients to other agencies? Which agencies

19. How productive are IST meetings?

Are you able to explore more options or strategies for individual cases as a result of IST meetings?

20. How do you come to agreement about each others'/agency's roles and responsibility?

21. How willing are you (or/and your organisation) to take the lead agency role? Why and why not?

22. How much influence and decision-making is shared among members?

23. How easy is to come to agreement of a shared plan?

24. How much workload is shared?

25. How satisfied are you with other sector's contribution?

26. How is accountability ensured?

27. What is the scope/complexity of the intervention plan? i.e. Need diverse specialities to accomplish collaborative goals? What kind of specialities? What are the skills and knowledge needed for your role in IST? Please comment on the capacity to deliver and goal implementation.

28. How likely to you think plan outcomes can be achieved? How do you anticipate outcomes of collaborative efforts?

29. Are the outcome measures [for this particular case] clear and realistic to you?
30. How has increased collaboration changed service to this child/young person and their families? Does the collaboration achieve its intention i.g. help overcome the fragmentation of service, bridging the gaps of services and reduce duplication? Give examples.
31. Does your involvement with intersectoral collaboration increase your job satisfaction within your organisation?
32. Does your involvement with intersectoral collaboration result in more productive and positive relationship with other agencies for your work?
33. How does your experience of being involved in IST change the way you work in other cases? do the wider community benefit from IST collaboration effort?

Other comments

34. Any other factors which supports and impediments have been experienced in building intersectoral collaboration?

35 Do you want a summary of my research report, which will be available next March? <If so, get an address>

Appendix 5.
Meeting Observation Form

| Subject # | Providing info | Seeking info | Goals/Strategies | Feedbacks about goals | Decision/Responsibility | Group Participation | Distraction | Non Verbal Behaviour | |
|-----------|----------------|-----------------------------|--|--|--|--------------------------------|------------------------|----------------------------|--|
| | Volunteer | # of questions | # of suggestions | # feedback given | Responsibility Refuse When asked | discouraging | unpunctuality | Boredom or dissatisfaction | |
| | Asked | elicit elaborated responses | incl. rationale /feasibility/ client acceptability | elaborate feedbacks than dis/agreement | volunteer | solicits others' contributions | Distracting behaviours | | |
| | jargon | | Interdisciplinary suggestions | | Decision Flexibility Rigid team decision joint solutions | | | | |

| | | | | | | | | | |
|--|-----------|-----------------------------|--|--|--|--------------------------------|------------------------|----------------------------|--|
| | Volunteer | # of questions | # of suggestions | # feedback given | Responsibility Refuse When asked | discouraging | unpunctuality | Boredom or dissatisfaction | |
| | Asked | elicit elaborated responses | incl. rationale /feasibility/ client acceptability | elaborate feedbacks than dis/agreement | volunteer | solicits others' contributions | Distracting behaviours | | |
| | jargon | | Interdisciplinary suggestions | | Decision Flexibility Rigid team decision joint solutions | | | | |

| | | | | | | | | | |
|--|-----------|-----------------------------|--|--|--|--------------------------------|------------------------|----------------------------|--|
| | Volunteer | # of questions | # of suggestions | # feedback given | Responsibility Refuse When asked | discouraging | unpunctuality | Boredom or dissatisfaction | |
| | Asked | elicit elaborated responses | incl. rationale /feasibility/ client acceptability | elaborate feedbacks than dis/agreement | volunteer | solicits others' contributions | Distracting behaviours | | |
| | jargon | | Interdisciplinary suggestions | | Decision Flexibility Rigid team decision joint solutions | | | | |

Appendix 6
Compiled Interview Responses

1. How well does your agency support local collaborative efforts?

“No support, there is no lesser work, you just do the best you can”.

“Financially yes”.

“I suppose...in terms of policy and finance”.

“I have more work to do but [I am] not allocated more time to do the work. HCN or not there is no special time allocation – I still have a normal workload”.

“Encouraged in general”.

“Yes they are supportive”.

“Not really”.

“Extremely well”.

2. Does being involved in IST change your role? If so, how? If not, why not?

“No, just another case”.

“It changes my approach [because] now I know who to talk in the agencies if I see a kid’s needs not being met – I have more contact with others in different agencies”.

“Yes, it has changed from managing crisis to providing more input in [my] field”.

“No, it just formalises what I have always been doing”.

“No, but as the nature of the needs are more complex, it forces me to cross discipline boundaries and not only looking at the kid’s educational needs – I have to take a more holistic position than say just mental health”.

“”No, no change”

“No, the job does not change and my responsibility does not change. However I do have to take on different roles for instance sometimes [being] an advocate, mediator, liaison, planning, coordinator or negotiator”.

“No”.

3. Does your line manager give you sufficient time to take part in intersectoral work?

“No, both the HCN and [agency] bosses do not realise the difficulties of the frontline staff and the impact of the red tape – there is actually very little time to do my work”.

“Yes, there is no restriction about the time. There is never any problem to attend the meetings but there is pressure to meet the workload”.

“There is significant amount of work up to the point where the application is approved. You are basically on your own during the set up. For instance, the set up of Sam’s case took 50 hours. However once it’s approved, it does reduce significant amount of workload”.

“No, I have to juggle”.

“It does not apply to me [because] I make my own decision about my time but my manager does support it”.

“No, there is definitely more workload especially the administration. For a typical case, 40% of the time is spent on meetings, 30% on paperwork and 30% on making phone calls etc.”.

“Yes, my immediate supervisor does...[because] my personal relationship with him...he trusts me...there is no formal structure as such though”.

“In terms of time, I have my normal caseload anyway. As far as funding goes, we do get behavioural support”.

4. Do your work colleagues support your involvement in IST?

What are the incentives and barriers to your role expansion?

What are ways to reduce barriers to role expansion

“Yes, I get the same amount of support as I would with other cases from my colleagues...our team has a very high level of support...usually via case conference or peer supervision. There is no barriers and not really a role expansion for me”.

“No I have the 3rd highest caseload in the region”.

“In spirit. [Child’s name] is just one of my 32 cases”.

“No. In my role it’s more like that I support my colleagues”.

“Yes, most of my colleagues have HCN experience, particularly the psychologists. The incentive is to think the cases through holistically and to work collaboratively with other agencies. The way to reduce barriers is to lighten to workload”.

“HCN definitely makes my life easier. The primary work is done by [name of Coordinator] which is really wonderful...[name of Coordinator] plays a central. Once the application is approved, I just attend the meetings and do the normal case tasks which I am doing anyway”.

“No, they are involved in their own cases but if it’s a crisis someone will fill in for you if you are absent”.

5. What kinds of training are available to prepare staff for collaboration work within the organisation?

“The supervisor should really provide guidance if you are lucky. The process is long and complicated and there is not a lot of support”.

“Nothing. There are courses for facilitators”.

“Just the general training you get during induction. I suppose you can say that [collaboration] is included in my discipline and my work...but really there is nothing specific for it”.

“No training. The set-up process is complex and constantly changing...[it is] not for the inexperienced”.

“None”.

“[It is included in] the general training...When I supervise someone, I would take them along to the HCN meetings to get field experience. Often I take those [who] are not directly involved [in the case] to the meeting to get the exposure”.

“Informally by talking to others who have HCN experience especially the clinical head”.

“None”.

“There is no formal training or workshops as such. However are workshops available to become the Strengthening Family Coordinator and plenty other workshops opportunity as part of ongoing professional development if you wish. You would need to prioritise to see which ones enhance your work the most”.

To what degree is the collaboration (info sharing, relationship building) part of your performance assessment criteria?

“Not really. I can get the same from other work and would rather do that than through HCN work”.

“What you are saying about [collaboration] is included in the general duty and I am expected to do it regardless”.

“None. Collaboration is expected anyway”.

“Not at all”.

“It is an integral part [which is] embedded in the performance appraisal. Interagency or intersectoral network is so critical. It is 10 out of 10 in order to do my job”.

“Yes, it is a crucial part. Especially family collaboration is pivotal”.

“It is built in as part of the job appraisal”.

“None”.

6. Please comment on the willingness and interest of your manager/colleagues for cases (intersectoral collaboration) like this in the future.

“Getting involved in HCN is just the luck of the draw really. It is geographically assigned. Saying that if someone is new he should be able to pick up a difficult case [like the HCN] or he can co-work with another more experienced colleague”.

“It’s okay as long as you manage your normal workload”.

“I don’t know about their willingness. For myself I wouldn’t want to have more than 2 cases at one time but I am willing to have HCN cases again. I’ve found that getting involved in HCN is a good experience overall”.

“My manager is extremely supportive. There is never any problem with time or resources”

“Neutral...they are told that they have to as a task. HCN approach is welcomed because the case is too difficult for one agency to deal with alone”.

“Yes the biggest benefit [with HCN] is that you don’t have to work alone with these most difficult kids and it reduced the time the field staff spent on them. Like you don’t have repeat the same information 10 times to different agencies”.

“Depending on the budget and resources...it is expensive and there is a lot of financial commitment involved for the agency but as long as it is important to meet the needs of the clients”.

“As long as you do a good job. HCN is the last thing you want to get involved...there is no incentives and no reward with added work...too much work...calls to make and too many reports to do. Whoever design the application should be shot”.

7. What is your attitude/belief towards intersectoral collaboration?

“It is a good idea but it depends on the results. I mean whether people has the skills to deliver them...like [name of team member] did not come up with any ideas for Chris’s education”

“It is a good thing. There are more benefits than limitations”

“Totally believe in it. The process could have been simplified a lot because the bureaucracy can put people off. HCN can reflect on why many people aren’t using the HCN resources”.

“It is crucial for the kids. However you do face a philosophical dilemma of the greatest needs v.s. greatest change. For example it is the worst ones [who] gets most of the money but this does not necessarily translate to the best outcome”.

“It has been a long time coming. In the past you have to rely on individual’s good will and those whom you know well”.

“My belief is that if it is helpful for the client then it is good. It is also helpful just to the services involved”.

“It is absolutely critical that people work together.

What are your views on the strengths and limitations of intersectoral collaboration approach?

“The style of coordinator is so important. [Name of Coordinator] is action orientated and is on to it. Our team members are genuinely interested and the attitudes are very positive. There is a lot of willingness to work collaboratively together. We are lucky...I know other teams just passing the bucket”.

“I really like it...the team approach gives more commitment and dedication. But one year is not long enough”.

“It offers more strengths than limitations. There are more brains to solve problems. The limitation is that it is hard to reconcile the fact that HCN kids gets almost unlimited funding whereas non-HCN kids gets only \$10 a week”.

“There are far more strengths than limitations. However HCN is such a daunting process...like the knowledge and the paperwork [it takes] to see the process through until the plan is approved. We have tried everything for these kids up till this point. Ideally we shouldn't have to wait until things have gone so bad. Resources and money should be available earlier in the kid's life”.

“The strength is the money and resources and the process is the limitation. I think they should have someone to do the application and not the field staff”.

“The incentives are funding...we can provide more intensive services. Also sharing the workload, the excellent team environment and having a facilitator who does all the logistics like taking care of the notes and the minutes and running the meetings...that is a great help. Barriers is the red tape...the process is clumsy and time consuming”.

“There is good clear communication with all the professionals involved. Also clear expectations of responsibility and accountability. One limitation is that in smaller city like Timaru the Coordinators are not as experienced in organisation and the process procedure. This makes the process difficult. The way to reduce this problem is to offer more training so they familiarise themselves with the HCN procedure...and to buddy up with an more experienced Coordinator”.

“The benefits are that you get more support from other agencies and more efficient in decision-making...[it is] also easier to mobilise resources and funding because of the common goal. The barriers are the time limitation and the group dynamics...some people talks too much. The time frame should be more flexible...you know the plan only goes

for one year...although you can extend it but generally speaking there should be more time to carry out the plan”.

“If there is a good team who is prepared to hang in there for a long time...especially when the plan doesn’t work out, they ask themselves what do we do now. The weakness is the personnel problem like you try to get a buy-in from [name of agency] – there is a difference of opinions of clinical diagnosis v.s. field work when you only see the kids once and they can fake good when they come in”.

8. How well do you know the other members from other sectors?

By first name?

How many times have you worked together in the past?

“Very well. Over the years I know their strength and weaknesses and what pushes their buttons. Yes, by first name. However I have never worked together in the past. this team is brand new to me. In fact it took 3 months before I feel I am an integral part of the team ”.

“This is my first time working together with [name of agency A] and [name of agency B]. I have daily contact with [name of agency C].

“I have never worked with them in the past but I know them really well”.

“Really well. I’ve worked with the core team members hundreds of times in the past because the nature of my agency. There is no problem when I need information and I can email and ring them anytime”.

“Very well. About 4 or 5 times on HCN cases and 40 to 50 times in general”.

“Very well. I know everyone from my work. I have worked with them so many times in the past that I cannot remember”.

“Not that well. I have never worked with them before”.

“Very well by first name. I’ve worked with most of them many times before”.

9. How well do you know the specific services of the other sectors?

Are there common elements in the services they provide?

“I know the general goals and there is no overlapping”.

"I know [name of agency A] system extremely well and reasonable well with [name of agency B].

"Very well and I am regularly updated with the information every 3 months formally... more frequently privately".

"I have good knowledge".

10. How important is intersectoral collaboration to the achievement of your agency's goals?

"Extremely important. For instance, I cannot be the kind of role model for troubled youth like Cross-Road or Reducing Youth Offending can. Also I cannot do my job until [name of youth] is happy to live somewhere and not constantly running away...or have a stable living environment When a kid is beaten and has no sleep, spelling test is the last thing on his mind".

"10 out of 10".

"Very important. It is impossible to do this without HCN [structure]".

"Very important. Without it the plan will fail".

"Very important for the kid concern. Average importance for our own organisation".

"It is vital not only for HCN cases but we should try all formal and informal ways of collaboration like Strengthening Families and make use of all collaborative effort available".

"Very important, particular for our [name of agency] and for the care and protection outcomes because no one agency can provide all the needs".

"Very important even though it does not reduce my workload. There needs to have the right people and the right plan to ensure the best use of the money. In Alex's case, spending money on ... was not a sensible plan".

11. How do the differences between agencies' priorities and policies affect the intersectoral collaboration process?

"I think other agencies do not realise how much pressure that we are under. They are very quick to point fingers at us".

“Not a problem”.

“They don’t seem to affect the process”.

“There is no conflict between the sectors because there is a clear role and responsibility for each agency”.

“The difference does not affect the process because we have a common interest which is to help the kid. Also the rules and expectations are realistic and clear”.

“Not an issue for the HCN process”.

“Time restriction mostly. Often the plan has to wait for funding from [name of agency] or we are waiting for [name of agency] to get teacher aid hours”.

“The protocol and the procedure of [name of agency] is so hard and complicated that it is not working. [Name of agency] is slow in acting and as a result things get so much worse”.

“The long waiting list from [name of agency A] means that the kids have to wait. In the meantime they are missing school and at risk of getting expelled. The response rate of [name of agency B] is also very slow”.

12. What are the types of conflicts (if any) you have noticed during IST meetings?

“Disagreement of opinions but usually its healthy debates because the HCN watchdog is there to keep us on track”.

“Just the general kind. Nothing big”.

“Who takes responsibility? Like placement between [agency A] and [agency B]”.

“No”.

“There is a problem with the contracted service providers not doing a satisfactory job because they never came to the meeting. [Name of Coordinator] should do something about it”.

“Never come across any”.

“Meetings take too much time...[it is a] waste of time”.

“None”.

“Reducing Youth Offending Programme is very good...They give the family 24/7 cell contact. I am not impressed with other professionals not doing what they said they would do”.

13. What kind of processes are in place for recognising and resolving conflict in the IST meetings? (e.g. patch protection/attitude towards collaboration)

“Nothing. I am not aware of any process for conflict resolution”.

“It is the Coordinator’s job to mediate outside the meetings”

“Not a big issue”.

“Don’t know. There is no need for that”.

“We are always able to come to agreement through healthy discussions amongst members. Especially for the [name of agency] workers, they can be backed up by the HCN team to go back to their agency with the money issues”.

“None”.

“HCN meetings puts pressures on individuals to [do their job]. HCN way is so good”.

“We are so lucky that we have a strong Coordinator. [Name of Coordinator] is a tower of strength. He never challenges people and people don’t feel threatened. He works quietly but persistently. We will be nowhere without him. He is the glue that holds us together”.

14. How is information sharing, openness and transparency achieved at IST?

“There is no hidden agenda. I think this is to do with [name of Coordinator]’s clarity of his own role and everyone else’s role”.

“Good. People interact professionally”.

“Through the Coordinator”.

“Excellent”.

“Great. Open and honest”.

“No problem”.

“Good. No problem in this area”.

“It’s difficult and tricky with [non professionals] are around. They should just stick to the plan. They don’t need to know about how funding is spent. This can lead to conflict between the caregiver and the parents. Also there are some interpersonal conflicts amongst the professionals... complaints to the [name of Coordinator]”?

“People don’t want to rock the boat... I mean respect them as individual but some people are more concern about their own reputation. There is not enough commitment. Some people only attend the meetings and that is all they do”.

15. In what ways can members support each other informally/formally?

“We had more energy at the start of the plan than now. [Name of Coordinator] is a bit airy fairy. He should be more clear about what he does as a coordinator and to tell others to contribute more”.

“People should be honest about what they think. As a team we need to send consistent messages to the providers. And also give each other positive feedbacks about our performance”.

“Not much. Very little if needed. Just follow the plan”.

“There is no difference from other normal cases”.

“More frequent phone and email discussions after the meetings”.

“I mentioned it before...as a team we can push for things to happen instead of fighting the battle with the structure individually”.

“People make alliance during the meetings but there is no formal system of contact outside the meetings. Regular update weekly would be good”.

“More communication”.

“Respect each other’s professional roles...being punctual, doing things you said you would do, give professional opinions and checking in with people...how you’re doing and is there any difficulty?”.

16. What are the existing linkages between agencies (sectors)?

“case by case and person by person. There is no join meeting or case conference for the three organisations”.

“It’s part of the job to link with other agencies”.

“We have a lot to do with each other because we have common clients”.

“Already there is link between”.

17. How often do you contact other IST members?

“Every 2 to 3 weeks. Monthly if things are going well”.

“No contact outside of the meeting except with [name of Coordinator]. I have more contact with the provider to keep myself updated with what is going on with the youth”.

“Monthly to quarterly”.

“None outside meetings”.

“Monthly on average. It only happens during the meetings”.

“Very seldom outside the meetings”.

“Every couple of weeks”

“weekly to monthly. It depends”.

“Not often, only at meetings because [name of coordinator] is so good at [keeping us updated]”.

“If [the plan] is working, every 3 months. More regularly if not. It depends on the stability of the youth. For example, when the plan is new or when the plan has broken down. It also serves a purpose to offer support to the service providers. We can brainstorm other options”.

18. To what degree do you exchange information with other sectors?

Do you/your agency refer clients to other agencies? Which agencies?

“Maximum. Yes”

“Yes”.

“Yes”.

“Open, no restriction...yes refer to each other”.

“No restrictions. Referrals to both agencies”.

“Yes to both questions”.

“No restrictions. Yes... to each other”.

“Yes. Yes”.

19. How productive are IST meetings?

“Not productive”.

“It is necessary for accountability”.

“Effective”.

“Very effective”.

“Very productive. It couldn’t function unless we’ve got it together”.

“Very productive. Never a waste of time...except for the “Name of town” ones”.

“For Alex, it is very productive. For other cases it is a waste of time”.

“Very good. It keeps the game up”.

“More and more. A year ago this was frustrating”.

Are you able to explore more options or strategies for individual cases as a result of IST meetings?

“Yes. People come up with good ideas to problem solve”.

“No”.

“Yes”.

“Yes”.

“Yes”

“There is potential to do so”.

“Yes”.

“Yes, we don’t meet for meeting’s sake”.

“Yes. Also we find crucial information to fine-tune stuff”.

“Yes. Strengthening the Families and Family Group Conference are low level of collaboration because there is no statutory power and no funding, whereas with HCN you have the mandated power to do things. We shouldn’t wait until things got to such a bad state”.

20. How do you come to agreement about each others’/agency’s roles and responsibility?

“It’s clear”.

“Mmmh...argue about it...people volunteer for it”.

“...volunteer mostly. [Name of Coordinator] will fill in contacting people about it”.

“Very easy. It is clearly defined by each Sector’s role”.

“No problem with this”.

“Clearly defined”.

“Clearly defined according to the Sectors”.

“It is volunteered. I am not prepared to challenge others if they don’t”.

**21. How willing are you (or/and your organisation) to take the lead agency role?
Why and why not?**

“Not willing at all. Avoid HCN if you can...there are unreasonable amount of forms to fill in”

“Not willing”.

“It’s fine”.

“We cannot take the lead agency role because of the HCN structure. It has to be one of CYFS, Mental Health or Education”.

“There isn’t a lead agency role. [Name of Coordinator] is employed to be the lead.

“Equally willing because it is a coordinator-led group”.

“The Coordinator leads”.

“Not willing at all”.

22. How much influence and decision-making is shared among members?

“The Coordinator has a huge influence. For instance, we wanted to employ a mentor for the kid but [name of Coordinator] said that ‘I am not sure if HCN will pay for 8 hours of mentoring. You see, I assumed that [name of Coordinator] was knowledgeable about HCN funding so I didn’t pursue it”.

“It all depends on the status...like if you are a psychiatrist, or if you are the guardian and also it also comes down to experience too. The decision about funding rests upon core IST agencies. If it is about the aims or the goals of the plan then everyone has a equal say. If it is about guardianship issues then only the parents of the CFYS, those with legal status make the decisions”.

“No problem in this area although ultimately it comes back to CYFS”.

“The legal status for the child overrides the HCN decisions. Say if the CYFS has the custody then CYFS has the ultimate responsibility of the child”.

“Equal power”.

“We are all equal. There is no imbalance of power. There is mutual trust from the professionals”.

“Personality driven”.

“In the beginning it was more of an issue that no decision was made rather than... As the team grew it became more equal”.

“Good”.

23. How easy is to come to agreement of a shared plan?

“There wasn’t real input from others. [Name of Coordinator] did it himself”.

“The majority rule. Although we don’t operate on a full consensus basis there is flexibility in [the team] to go along with team decisions”.

“Yes it is easy”.

“It is really easy because all the facts are there and everyone has a common goal to work for the best interest of the young person”.

“Very easy. We are all on the same page at the end of the meeting”.

“No problem”.

“It is fine”.

24. How much workload is shared? How satisfied are you with other sector’s contribution?

“Shared equally...it depends on the nature of the client’s needs”.

“Very happy”.

“Good”.

“It depends on the needs of the kids...on which sector’s area the needs fall. It also depends on the individual’s personality. People generally do a good job”.

“The youth is the primary mover...it depends on the main areas of needs. I am more than happy with others’ contribution. Especially when people turn up and they are proactive within their own sector, it makes my life easier. Often it is hard to get other sectors to do things”.

25. **How is accountability ensured?**

“By the mechanism of HCN quarterly review”.

“The regular meeting works well as an effective mechanism. You know you will see them quarterly so you have to do what you said you would do”.

“Meetings. Accountability is the requirement of the process”.

“This is not an issue. There is an expectation of full attendance. If not, I will be talking to their managers”.

“The accountability is in-built as mandated to the agency”.

“It is up to the Coordinator to remind...It is better for the agency to be more responsible in their area”.

“There wasn’t any! I think [name of Coordinator] is not assertive enough...or he did not engender enthusiasm”.

Task characteristics

26. **What is the scope/complexity of the intervention plan? i.e. Need diverse specialities to accomplish collaborative goals? What kind of specialities? What are the skills and knowledge needed for your role in IST? Please comment on the capacity to deliver and goal implementation.**

“Yes, people do have the skills but not the willingness...low morale. Sometimes it feels hopeless and not sure if the plan can work”.

“Yes, they do. Skills are not the limitation here. The case can be very complex but it requires a minimal of 3 agencies to work. The plan will collapse as a result of one of them pulling out”.

“The skills of the Coordinator are absolutely pivotal – they can make or break the plan”.

“Yes”.

“Adequate”.

“Because we don’t have to plan the dual role of a facilitator we don’t need upskilling or training. What will be helpful is a booklet on HCN procedure”.

“Apart from [name of team member]”.

27. How likely to you think plan outcomes can be achieved? How do you anticipate outcomes of collaborative efforts?

"I am very confident that there is a high chance that plan is successful. This is largely due to the strong personalities at Cross Road. They are not even a recognised provider but they are very committed. Their methods are a bit unconventional but it helps to break the boundaries for Sam and it works".

"I hope so".

"There is a 50% of chance because the cases are so difficult. It may need longer HCN plan and more money".

"Very likely because people have realistic goals with the resources available. The only limitation here is the 12 months timeframe".

"Short term, the plan can be actioned. Long term I am not sure".

"Yes, the plan is realistic and achievable. The success is however up to the individual at the end of the day".

"I am optimistic. Time is the only constraint".

"I think the long term goals for Chris is a bit unrealistic because it also depends on his motivation and understanding of what we are trying to do for him. I am more hopeful for another case where I feel the goals are achievable".

"It is unworkable. The plan didn't fit Sam. I don't think there is enough understanding of Sam. Sam is not your average Kiwi kid. Normal rewards won't work for him".

28. Are the outcome measures [for this particular case] clear and realistic to you?

"No. they are unrealistic".

"Yes".

"Yes".

"It is difficult to measure the outcomes because it is up the youth totally. He may still end up in prison but at least we give him some options so it is not money down the drain".

"Not the big long term goals like living independently and hold down a job".

"Yes. We own them...kids... through the State system".

"Yes they are realistic and achievable and not the academic ones".

“Yes”.

“Yes but Chris goes through the honeymoon period. He has all the chances if he steps out of line”.

29. How has increased collaboration changed service to this child/young person and their families? Does the collaboration achieve its intention i.g. help overcome the fragmentation of service, bridging the gaps of services and reduce duplication? Give examples.

“It makes the services more productive”.

“Yes. For Sam’s case, he has such a family history and environment that he finally has an opportunity to do something worthwhile like live with no crime and possibility holding down a job”.

“It has made a huge difference and turned his life around. This is his best chance so far in his life to have a safe structure”.

“It has made a huge impact. The money is well spent and everyone is very positive about the results. HCN gives hopes when there hasn’t been any”.

“There are more resources available to the individual and the family”.

“I hope it does make an impact long term. Currently it makes no difference to the kid and the family because he is in CYFS custody for reasons of parental negligence...unless the family are on board. Still they won’t catch the nuisance of how HCN involvement is different from normal services”.

“Yes. However, you can do your best, ultimately it depends on the individual”.

“It stops them from splitting the professionals and it encourages family to take shared responsibility”.

“Not a lot. There is not enough communication with the family and the professionals”.

30. Does your involvement with intersectoral collaboration increase your job satisfaction within your organisation?

“No. I will never ever want to get involved again. I will avoid it like a plague”.

“No. It is a routine process within many processes we use. Just part of my job”.

“Yes, definitely”.

“It does increase my personal satisfaction. I am passionate about it. I feel privileged to be involved and I can see the results”.

“Yes because there are other kids whose [problems] not severe enough to get such a good chance”.

“Absolutely. I adore my job and I am excited about Monday morning.”

“Yes as far as HCN goes...”

31. Does your involvement with intersectoral collaboration result in more productive and positive relationship with other agencies for your work?

“Yes”.

“Yes but I work on my relationships all the time anyway”.

“Yes. We work closely face to face instead of voice messages on the phone”.

“It does...over the wider spectrum”.

“Yes”.

“I want money [to do my job] and that is my main motivation. HCN is money and collaboration is secondary...you do it anyway.”

“Yes”.

“No. In fact I lost respect for some people. It affects my confidence in [making]future referrals”.

32. How does your experience of being involved in IST change the way you work in other cases? do the wider community benefit from IST collaboration effort?

“Yes, it has changed my way of working. In the past I had a more individual’s approach. I see that I have to collaborate more in order to be more effective. We need to work closer together physically too like there is no CYFS at our area and we have to travel to [name of district]. We need to have unit locally. Weekly contact is ideal”.

“No. this idea is not unique we already quite involved with [name of agency A] and [name of agency B]. The hardest group to work with is [name of agency C]. They are under- resourced, under-staffed and have huge caseload. It is very difficult to get [name of agency] to return a call”.

“No. Collaboration is not a new thing...its more flavour of the month at the moment. Traditionally I have always worked collaboratively and am expected to do so and I encourage my new staff to do the same”.

“No. HCN is a bad experience but it does not put me off teams. I would still work with teams when it is appropriate. HCN has the potential to work well”.

“Yes, it makes realise how much effective to work in groups and ineffective to work in isolation”.

“Yes I am able to see from others’ perspectives”.

“No. If I can get money via an easier way I go for the easy way”.

“No. I will always work this way”.

“Probably not for me because I’ve always work this way but it gives others the opportunity to open their eyes”.

“No”.

“No. I have the same enthusiasm”.

Other comments

33. Any other factors which supports and impediments have been experienced in building intersectoral collaboration?

“The level of HCN could be lower so we can have earlier interventions”

“More seamless interactions and closer links between agencies. A local one-stop shop...geographically organized in one building that is child and family centred. At the moment HCN is like the ambulance at the bottom of the cliff”.

“Previously I had bad experience with high needs kids...or negative interactions with individuals at other agencies”.

“Mental health has always been an area that is overlooked in terms of support and resources. HCN is too much individually based...how about sibling groups?...they all come from the same bad family and one gets HCN others left out...”

“There is constantly new forms and new HCN process and procedures to follow. They at the top need to be clearer and consistent in their expectations. You would have to be very confident to put your feet in HCN process. In Christchurch there are only a handful know it well enough to go down this path”.

“The time and the number of agencies involved”.

“It is helpful if you have contact with others in other areas or if you have previous work relationships is good for the familiarity... and the respect for each other”.

“It is hard to get people together for a meeting. It is more effective [to work] one to one than....More informal networking would be more effective and more efficient use of time. People are more comfortable sharing individually than being in a team situation. You can just hide or go along for a ride in the meeting... Micro rather than macro”.

Appendix 7.

Rating Individual Participation In Teams scale (Bailey & Helsel-DeWert, 1981)

RATING INDIVIDUAL PARTICIPATION IN TEAMS

Don Bailey, Ph.D. and Marjorie Helsel-DeWert
 Frank Porter Graham Child Development Center
 CB #8180
 University of North Carolina at Chapel Hill
 Chapel Hill, North Carolina 27599

Overview

This scale is designed to measure the behavior of individuals in the context of an interdisciplinary team meeting. It was developed out of a need to objectively sample the broad range of participation/collaboration behaviors and to provide meaningful feedback for training and improving collaborative behavior. A comprehensive study of the scale's reliability and validity is reported by Bailey, Helsel-DeWert, Thiele, and Ware (1983).

Organization

The scale consists of 17 items organized into five subscales: Preconference Preparation, Providing Information, Participating in the Group Process, Distractions, and Nonverbal Behavior. The subscales have been verified through components analysis. Each item is rated on a scale from 1 to 5, with behavioral descriptors for ratings of 1, 3, and 5.

Observing Participation

The first 3 items of the scale must be completed by self-report. The remaining items are scored on the basis of direct observation. A coding sheet (see attached) is used to facilitate data collection. When read from left to right, the columns of the form correspond roughly to items 4 through 17 of the scale. The first four columns have been further subdivided into sections corresponding to the behavioral descriptors provided for the items being rated. Each row of the form represents the data to be collected on one team participant. Observers should note each occurrence of a target behavior by making a mark in the appropriate section of the tally sheet. When it is unclear how a given behavior should be rated, the observer should make a note of the behavior and its antecedents in the appropriate column. Refer to the tally sheet when completing the final rating form for each participant at the conclusion of the meeting.

Scoring

In order to receive a given score, all stated criteria must be met. If the team member meets all of the requirements for one level and only some for the next, assign an intermediate score. For example, item III.C measures the extent to which an individual provides feedback to other team members. If feedback is given on two suggestions by other team members, but only one of those instances of feedback is more than simple agreement or disagreement, the individual should be given a rating of "4".

Using the Scale

The scale can be used as a measuring device for research purposes or as a tool for providing feedback to team members. Our research to date, however, suggests that individuals vary their behavior across team meetings, and thus one observation may not be sufficient to obtain an accurate picture of typical participation. Two observations, however, generally are sufficient.

Modifying the Scale

Most of the items should be scored exactly as indicated on the scale. One exception is item 1.13 - Submitting Reports Prior to Conference. In order to receive a rating of 5, the team member must submit all required reports at least one week prior to the team meeting. This time frame was chosen because of the specific requirements at the institution where the scale was first developed. The actual times assigned to item 1.13 may be varied according to local agency regulations.

Evaluation of the Scale

The authors are very much interested in feedback regarding usability of the scale. Please send any comments to the first author.

Reference

Bailey, D. B., Helsel-DeWert, M., Thiele, 1, & Ware, W. B. (1983). Measuring individual participation on the interdisciplinary team. *American Journal of Mental Deficiency*, 88,247-254.

RATING INDIVIDUAL PARTICIPATION IN TEAMS

Don Bailey and Marjorie Helsel-DeWert

1. PRE-CONFERENCE PREPARATION

A. Preparing reports prior to conference

| | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
| Fails to complete any required reports or assessments | | Partially completes required reports or assessments | | Completes all required reports or assessments |

B. Submitting reports prior to conference

| | | | | |
|---|---|---|---|--|
| 1 | 2 | 3 | 4 | 5 |
| Submits reports day of team meeting, or does not submit report at all | | Submits all reports at least three days prior to meetings | | Submits all reports at least one week prior to meeting |

C. Reviewing reports of other team members prior to conference

| | | | | |
|---|---|---|---|--|
| 1 | 2 | 3 | 4 | 5 |
| Does not read any available reports prepared by others prior to meeting | | Reads half of all available reports prepared by others prior to meeting | | Reads all reports submitted by others prior to meeting |

II. PROVIDING INFORMATION

A. Providing information

| | | | | |
|--|---|---|---|--|
| 1 | 2 | 3 | 4 | 5 |
| Does not verbally contribute any information regarding client during meeting | | Shares information about client when asked. Information is more than simple yes or no | | Volunteers information about client at least twice |

B. Delivering information

| | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
| Reads all reports verbatim or does not contribute information | | Some information presented in conversational manner | | All information shared in conversational manner |

C. Using technical terms or jargon specific to a given profession

| | | | | |
|--|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
| Consistent use of unexplained technical terms or jargon, or says nothing | | Occasional use of unexplained technical terms or jargon | | Comments are clear to all, including parent or guardian |

III. PARTICIPATING IN THE GROUP PROCESS

A. Seeking information

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|--|
| Raises no questions about client, programming or data given by other team members | | Raises two or more questions or issues for discussion | | At least half of questions or issues raised for discussion elicit more than a yes or no response |

B. Suggesting goals, objectives, or strategies for goal implementation

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Makes no suggestions for goals, objectives, or strategies for goal implementation | | Makes two or more suggestions for goals, objectives, or implementation strategies acceptability of services to client | | Makes two or more suggestions. Each includes rationale or discussion of feasibility and |

C. Providing feedback on goals, objectives, or implementation strategies

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Does not provide feedback on any suggestions by other team members or gives feedback in socially or professionally inappropriate manner | | Gives verbal feedback on two or more suggestions by other team members. Feedback given in socially or professionally appropriate manner | | Gives feedback on two or more suggestions by other team members. Feedback is more than simple agreement or disagreement |

D. Group Discussion

| 1 | 2 | 3 | 4 | 5 |
|---------------------------------------|---|--|---|---|
| Discourages others from participating | | Makes no attempt to keep others from participating | | Solicits feedback or contributions from other team members, including at least one who is not actively involved in the discussion |

E. Flexibility

| 1 | 2 | 3 | 4 | 5 |
|---|---|--------------------------------|---|--|
| Shows unwillingness to modify opinions or recommendations | | Goes along with team decisions | | Actively works with team members to reach a joint solution |

F. Accepting personal responsibility

| 1 | 2 | 3 | 4 | 5 |
|--|---|-----------------------------------|---|-------------------------------------|
| Refuses or avoids accepting responsibility | | Accepts responsibility when asked | | Volunteers to accept responsibility |

G. Suggesting interdisciplinary goals or activities

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|--|
| Makes suggestions which relate only to own discipline, or makes no suggestions at all | | Makes suggestions for specific disciplines other than own | | Makes suggestions which involve the cooperative efforts of two or more disciplines |

IV. DISTRACTIONS

A. Arrival and departure

| 1 | 2 | 3 | 4 | 5 |
|--|---|---|---|---|
| Arrives late and leaves early without adequate explanation | | Misses part of meeting, but offers explanation to group or notifies team leader ahead of time | | Arrives on time and remains for the duration of the meeting |

B. Distracting behaviors during meeting

| 1 | 2 | 3 | 4 | 5 |
|--|---|--|---|-----------------------------------|
| Exhibits many distracting behaviors (e.g., tapping pencil, whispering) | | Exhibits some distracting behaviors during meeting | | Exhibits no distracting behaviors |

V. NONVERBAL BEHAVIOR

A. Position in relation to group

| 1 | 2 | 3 | 4 | 5 |
|--|---|---|---|-----------------|
| Sits on periphery; clearly not a part of the group | | Sits close to group but still not obviously-part of group | | Sits with group |

B. Body language

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Body position generally reflects boredom or dissatisfaction | | Body position generally reflects neutral attitude | | Body position reflects active interest in proceedings and acceptance of group members |

Appendix 8.
Information on the High and Complex Needs Unit

Guidelines for Application and Plan Processes

Contents

| | |
|----------------------------|----|
| Introduction | 1 |
| The Processes at a Glance | 2 |
| Identifying HCN Candidates | 4 |
| Local Prioritisation | 6 |
| National Moderation | 7 |
| Plan Development | 9 |
| Plan Approval | 10 |
| Plan Implementation | 11 |
| Plan Review | 12 |
| Plan Modification | 13 |
| Emergence | 14 |
| Glossary | 15 |

A joint strategy of the Ministries of Health and Education
and the Department of Child, Youth and Family Services

‘Me mahi tahi tatou’



child, youth
and family



MINISTRY OF EDUCATION
Te Tāhuhu o te Mātauranga



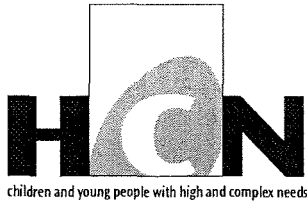
MINISTRY OF
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MANATŪ HAUORA



Te Puni Kōkiri
Ministry of Māori
Development



MINISTRY OF
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Tēnā koutou katoa.

These Guidelines explain the Application and Plan processes for intensive support and intervention packages, formerly known as System 3, of the High and Complex Needs Strategy.

Our processes are designed to make sure that we identify and work with those children and young people with the highest and most complex needs that cannot be met through locally available services.

The processes are based on local knowledge and experience across the sectors, and with families/whānau.

The HCN Unit has developed these processes to ensure that children and young people are accepted for funding on principles of consistency and equity, and have equivalent levels of unmet need, regardless of what part of the country they come from.

We seek to work in partnership with local intersectoral teams as they develop their plans, based on accepted clinical understandings and inspirational thinking about effective practice, and Plan Advisers are available to offer active support. The Advisers will continue their support throughout the development of the plan, its implementation and review, because we are committed to working with local teams to achieve the best outcomes for these children and young people.

Waiho i te toipoto, kaua i te toiroa.

Let us keep close together, not far apart.

We look forward to working in collaboration with you.

Nāku noa, nā,

David Russell Jones

HCN Unit Manager

THE PROCESSES AT A GLANCE

Identifying HCN candidates

Either:

- A fieldworker identifies that a child or young person (CYP) on their caseload has exceptional needs, and believes that these needs cross over into at least one other sector, in which case a local intersectoral casework team (IST) must be established

or:

- An existing IST recognises that a CYP it already supports has needs so high and complex that they can be met only through additional funding

Either way, IST meetings must take place before an application can proceed.

Need profiling and information collation

Various assessments will have already been completed by the sectors involved. The HCN Unit will help the IST collate this information in a number of ways, including:

- A statement of the needs and strengths of the CYP
- The current and past services received by the CYP
- A summary of the thinking so far about how the child's needs may be addressed

Local prioritisation

A locally based meeting of sector managers reviews all applications before submission to the Unit.

The meeting ensures that all local solutions have been explored and all appropriate local services have been accessed. The managers determine applications are only made for those CYPs from their area with the highest and most complex unmet needs.

Where a decision is made not to submit a particular application, the CYP's progress will continue to be supported and monitored through the existing sector services.

National moderation

Applications are submitted to the Unit for moderation to ensure that those CYPs with the highest and most complex unmet needs across the country are accepted for funding.

Plan development

Within three months of the CYP's acceptance through the National Moderation Panel, a plan is developed by the IST with support from a nominated Plan Adviser from the Unit. It should establish long-term goals and the steps needed to achieve them. The plan should also identify the resources required and propose a budget.

Plan approval

The plan is submitted to the Approval Panel, which meets fortnightly. The Panel determines that the plan meets the needs of the CYP, decides which aspects of the plan can be funded and establishes a review procedure, review dates and the key outcomes to be reviewed.

Plan implementation

The plan is put into action to allow the co-ordinated delivery of the services and interventions required for the CYP.

The plan itself details what interventions will be carried out, and how, over a period of up to one year. The roles of those who will implement the plan are also identified.

Plan review

The plan is reviewed quarterly at local level. The IST needs to ask:

- Has it been effective?
- Are any modifications necessary?
- What are the next objectives?

A report of the review is sent to the Approval Panel, which must consider any proposed changes to strategies or budgets.

Plan modification

If the CYP does not respond to intervention as anticipated, changes to the plan may be required at short notice.

The IST meets to formulate modifications and proposes them to the Approval Panel, which will consider them at its next fortnightly meeting.

Emergence

When the CYP becomes eligible for adult services, or when their needs have reduced to the level at which they can be met by locally available services, the IST should develop a plan for the CYP's emergence from HCN funding. The plan should minimise disruption to the CYP during the specified period.

If the IST does not consider that the CYP is ready for emergence, a revised plan for the next year should be prepared as under 'Plan development'.

If the CYP has emerged from HCN funding, the Unit will ask the IST for an assessment of how well their gains have been maintained after one year.

THE PROCESSES IN DETAIL

Identifying HCN candidates

The purpose is to identify through intersectoral case management those children and young people with the highest and most complex unmet needs across at least two sectors (Health, Education and CYF) who would benefit from HCN funding. For this purpose a child or young person is either:

- Under 17 years old
- or
- Under 21 and agencies have explored all opportunities for accommodation within adult services and all adult services have been established as unsuitable

Timing

A decision to pursue an application to the HCN Unit may be made at any time.

People involved

- The child or young person and their family / whānau must be included in the process, in whatever way is most appropriate
- Fieldworkers

The titles of positions will vary across locations and sectors but may include:

- *CYF*: social worker, supervisor, senior practitioner, psychologist
- *Education*: Group Special Education (GSE) psychologist, physiotherapist, occupational therapist, special education adviser, kaitakawaenga, speech and language therapist, early intervention teacher
- *Health*: public health nurse, community nurse, mental health social worker/therapist, disability needs assessor, psychologist, psychiatrist, paediatrician, social worker, physiotherapist, occupational therapist, speech and language therapist
- Line managers of the fieldworkers

The process

The process builds on intersectoral casework already occurring around the child or young person. The intersectoral casework may be using either the Strengthening Families Case Management model or other intersectoral forums operating within a given geographical area.

If intersectoral case management has not yet occurred

It is possible there will be individual children or young people who have significant intersectoral needs but either they have been managed within a single sector or consistent intersectoral working has not occurred. In either case, an intersectoral case management team (IST) must be established before an HCN application may be made. Several intersectoral case management meetings may be required to identify all the current agencies and services being delivered to the child or young person.

Managers will need to support the decision to apply and ensure that staff are given the time necessary to take part in the work this will involve.

Each manager will need to know:

- What information is known about the casework occurring in the other sectors?
- Is the child or young person seen as a high priority within the other sectors?
- Has the family given consent for their information to be shared with sectors?
- What intersectoral case management mechanisms will be used (eg Strengthening Families)?

The lead agency caseworker then approaches the other sectors to begin intersectoral case management. If the IST decides that additional services are required to support the child or young person, then an HCN application may begin.

If intersectoral case management has already occurred

Managers will need to support the decision to apply and to ensure that staff are given the time necessary to take part in the work this will involve. The manager will need to know:

- Has family consent been obtained?
- Have all relevant assessments been completed?
- Who else is involved with this child or young person (other sectors, non-government organisations (NGOs), ACC etc)?
- Have all agencies been involved in planning to date?
- Is this child or young person seen as a high priority within the other sectors?
- Have all service options in the locality been explored?

Approaching the HCN Unit

A nominated person from the IST should contact the Unit for information about the application process and the support that the Unit can provide.

The Unit will provide the documentation required to submit an application.

Completing the documentation

IST meetings now need to occur to complete these documents. Unit Plan Advisers can support and explain this process. Forms are available both in hard copy and electronically from the Unit and can also be downloaded from the website at www.hcn.govt.nz. The information required will already be available from the assessments and planning that have been carried out within each sector.

Prior to the first meeting the IST needs to ensure that the information and views of the child or young person and family / whānau have been sought. It is often appropriate for them to attend the meetings.

Once the documentation is complete, it is forwarded for consideration at the next local prioritisation meeting.

Local Prioritisation

Local prioritisation meetings are an important step in the HCN process to:

- Help foster intersectoral collaboration
- Ensure that local people are driving the process and making local decisions
- Establish that the child or young person is among those with the highest and most complex unmet needs in the locality
- Ensure all local solutions have been explored
- Ensure that local managers are aware of all HCN applications from their locality
- Approve applications for submission to the Unit

Timing

Prioritisation meetings should be held as required. There is no requirement for a meeting to be held specifically to complete the prioritisation work, so it may be appropriate to have the prioritisation process as an agenda item at a regular intersectoral meeting.

People involved

Managers who are able to authorise an individual child or young person's plan and expenditure for their sector.

The process

It is crucial that the child or young person's family/whānau or legal guardians are aware of the local prioritisation meeting and have given consent for information to be shared at that meeting.

The prioritisation meeting will consider application information provided for each child or young person. In addition one IST member should be available by phone if there are any questions.

Minutes should be kept of the meeting and the Unit advised of how many applications were considered at the meeting and how many were approved.

Feedback to IST

Each IST needs to be informed about the outcome of its applications, and should receive any suggestions for services from those at the prioritisation meeting. For example, the meeting may have identified further local solutions prior to submitting an application.

Where a decision has been made not to submit an application, the method of monitoring the child or young person's progress needs to be identified. Should their situation change, an HCN application may become appropriate.

IST response

The intersectoral team will act upon the feedback from the prioritisation meeting.

This could mean one of the following:

- Work continues towards submitting the application
- Suggestions from the prioritisation meeting are implemented to assess their effect before continuing on the application
- Both of the above

National Moderation

If the prioritisation meeting decides to proceed with an application, it should be submitted to the HCN Unit for national moderation. This process helps to ensure that resources are directed towards those children and young people with the highest and most complex unmet needs nationally.

Timing

National Moderation Meetings will be held every two weeks.

People involved

The National Moderation Panel consists of one clinician or senior practitioner from within each sector with:

- * Extensive knowledge of the services delivered by their sector
- * Strong networks within their sector
- * Credibility within their sector

The process

The Unit acknowledges receipt of the application, confirms the date of the next meeting of the National Moderation Panel and assigns a Plan Adviser to the case if this has not already been done.

National Moderation Meeting

Participants at the National Moderation Meeting:

- * National Moderators
- * Unit Manager

The National Moderators will assess each application. Each Moderator will state their view from their sector's perspective, on whether the application should be accepted or rejected. The National Moderators will discuss the application to reach a decision acceptable to all three sectors.

In some circumstances the Plan Adviser may hold information that would assist the Panel with a decision. If information about the application is gained through the Plan Adviser at the meeting the minutes must record the information given and the subsequent decision.

The National Moderators may request further information, via the Plan Adviser, from the applicants to assist the decision-making process.

Where the National Moderators are unable to reach a decision they will either get further information on the child or young person's needs from the IST, via the Plan Adviser, or seek further information about service availability from the appropriate sector(s).

Minutes of all meetings will be kept.

The applicants will be informed in writing by the Unit Manager within three working days of the outcome of the National Moderation Meeting.

Requesting a review of a Moderation Panel's decision

A review may be requested if:

- * The IST feels that the Panel has not taken sufficiently into account information provided with the application
- * The child or young person's needs have changed since the original application
- * Significant information was omitted from the original application

Plan Development

A plan is developed to co-ordinate the resources allocated and interventions implemented for the child or young person, so they focus on his/her needs in a way that is most likely to lead to positive gains.

Timing

The plan will be developed as soon as possible (generally within six weeks and no later than three months) following the child or young person's acceptance through national moderation. The Unit will provide funding of \$1,200 for key worker time to help this process.

People involved

The Local Services Co-ordinator (LSC), who is employed by or contracted to the lead sector, convenes an IST meeting. Parents, caregivers and whānau should also be invited. The nominated Plan Adviser is also a key player. Where the IST has a particular provider in mind to deliver the programme and interventions identified in the plan, it is inappropriate to involve them in the development of the plan, unless for instance they are already involved with the child or young person and their knowledge will form a useful contribution to the plan.

The process

In developing the plan the team needs to:

- * Identify the steps or objectives that mark the path towards achieving agreed goals for the child or young person
- * Decide on the strategies to achieve these objectives
- * Be informed by current knowledge and understandings about best possible practice in relation to the child or young person's needs (the Plan Adviser can assist with access to clinical and practice advice)
- * Describe the expected outcomes using objective language ('SMART' terms)
- * Refer back to the Service Profile to identify the resources (including human, physical and financial) required for the plan, over and above the services that the child or young person is already accessing
- * If appropriate, involve any proposed provider in clarifying costs of the required services (this information will be needed for the budget section)

It is important that the parent/guardian and the child or young person understand and agree with the objectives and long-term goals of the plan.

Final sign-off by managers of each of the sectors involved denotes a commitment to support the child or young person at the level for which he/she is eligible for the duration of the plan.

Plan Approval

Once agreed locally, the plan is submitted to the Plan Approval Panel to ensure that it:

- Proposes interventions that fit well with the needs of the child or young person, and are consistent with effective practice
- Has been developed with input from all key people
- Is recorded in a format that will help achieve the expected outcomes, objectives and goals for the child or young person
- Represents an efficient and effective use of the Unit's resources

When?

Fortnightly Approval Panel meetings.

People involved

The Unit Manager and Plan Advisers.

The process

Copies of the submitted plan are sent by the Unit to all Panel members a week before their next meeting.

The Panel discusses the content of the plan and should reach consensus on:

- Which aspects of the plan to fund
- The timing of the first review meeting
- The key outcomes on which the review will need to focus

The Panel's decisions will be communicated in writing from the Unit Manager to the LSC within 5 working days.

Plan Implementation

The purpose of the plan is to deliver the proposed services, supports and interventions in a way that achieves the required outcomes for the child or young person.

Timing

The plan can cover a period of up to a year. It may spell out times at which different interventions may be applied.

People involved

The plan will be implemented by all those who are identified within it. The LSC will have the key day-to-day liaison, with the support of the IST.

The process

The plan itself makes clear how the interventions will be carried out. Any significant changes should be discussed with the Plan Adviser.

Plan Review

Regular reviews are needed to evaluate the effectiveness of the plan, to modify strategies and to set new objectives and/or outcomes as soon as current ones have been achieved. The focus must always be the achievement of positive gains for the child or young person, and preparation for emergence from HCN support.

Timing

Reviews will be held at least quarterly.

People involved

All members of the IST, including representatives of any providers and whānau, caregivers/guardians. The views and comments of the child or young person should also be sought. The Plan Adviser should be present for at least the first and the third quarterly reviews. The Clinical Adviser should be present at all review meetings.

The process

The LSC will convene the review meeting, and seek feedback from appropriate IST members regarding the expected outcomes identified in the plan. The team will revise the objectives as appropriate and identify any required modifications to the intervention strategies. These will be recorded on the plan form and the team will also consider and respond to the other review questions. The Plan Adviser will be able to support this discussion.

The Plan Approval Panel will consider review reports at its fortnightly meetings and will comment back to the IST through the standard review letter.

Plan Modification

The path for children and young people with high and complex needs is often unpredictable and circumstances will arise which require sudden and significant changes to the plan and speedy approval of budget amendments. While the 'Crisis Management' section of the plan is intended to anticipate and cater for some of these eventualities, there will be many cases in which it does not. The Unit needs to be able to support quick and effective decision-making in these cases.

Timing

As necessary.

People involved

LSC, Clinical Adviser and other members of the IST, Plan Adviser and Approval Panel.

The process

The LSC, in discussion with members of the IST, makes amendments to the plan. Where the changes have budget implications or mark a new intervention direction, the LSC must make sure that they have the approval of the Clinical Adviser, and communicate them to the Plan Adviser. They are discussed at the next fortnightly Approval Panel meeting, and responded to in writing as above. The plan template and budget will be amended accordingly.

Emergence

HCN funding is not intended to be long-term. Its emphasis is always on supporting children and young people to achieve and maintain positive changes that will reduce the intensity of their need for individual intervention and allow them to be appropriately supported through locally available services.

Timing

When the child or young person's needs have reduced to the level at which they can be supported through locally available services, or when they become eligible for adult services.

People involved

The IST (including whānau/caregivers and with input from the child or young person). Plan Adviser and Approval Panel.

The process

The third quarterly review needs to consider in detail what the child or young person's needs will be at the end of the year for which the plan was developed. If their needs can be supported through locally available services, then the IST will need to develop an emergence plan that minimises disruption to the child or young person.

It should:

- Specify the period of time it covers
- Be recorded on the plan form
- Be submitted to the Unit for approval (see page 10)

If the child or young person is not considered ready for emergence, a revised plan for the next year can be submitted to the Unit for approval.

One year after a child or young person has emerged from HCN funding, the Plan Adviser will seek information from the IST about how well the child or young person's gains have been maintained.

Glossary

CYP: a child or young person who for HCN purposes is either under 17 years old, or under 21 and agencies have explored all opportunities for accommodation within adult services but adult services have been established as unsuitable.

Clinical Adviser: a member of the IST who has expertise appropriate to the CYP's needs and with whom the team can consult over the clinical direction of the plan.

Emergence: the point at which the CYP is ready to make the transition from HCN funding to services and supports that are available within the sectors.

HCN intervention plan: the intensive individual intervention plan that will be put in place for CYPs who are accepted for HCN funding. These comprehensive plans are developed collaboratively by the intersectoral team in consultation with the CYP and family/whānau. They are recorded on a standard Intervention Plan form and include the following elements:

- Long-term goals – balance optimism with realism and are the focus of achievement within three years
- Objectives – state clearly what changes and gains for the CYP are to be focused on over the next three months
- Resources – spell out what will be required to achieve these changes, including human and material changes
- Outcomes – should specify in SMART terms how it will be known that these gains and changes have been achieved

Highest and most complex needs: refers to the level and type of needs of CYPs who are the recipients of funding for Individual Support and Intervention Packages. These needs are extreme and are further complicated by the fact that they present across many aspects of the CYP's life.

Intersectoral team (IST): a team of fieldworkers from all the sectors and agencies that are actively involved in supporting the CYP, including the family/whānau.

LSC: see Local Services Coordinator.

Lead sector: the sector in an IST for supporting a CYP (either Health, Education or Child, Youth and Family) which takes responsibility for identifying and employing the LSC and for managing the budget for the plan.

Local prioritisation: the process by which suitable candidates for HCN funding are identified and prioritised at a local level by representatives of managers from the three sectors.

Local Services Coordinator (LSC): a key worker who is a member of the IST (and employed or contracted to the lead agency) who carries out the intensive case coordination that is required for the effective implementation of HCN plans. A more detailed role description is available from the HCN Unit.

National Moderation Panel: a group of senior representatives from each of the sectors who together with the Unit Manager ensure that decisions about which CYPs to accept for ISIP funding are made with equity and consistency. In other words, this panel makes sure that children with similar levels of need are accepted for funding, regardless of differences in type of need or in geographical location.

Plan Approval Panel: the panel of HCN Unit staff who consider and make funding recommendations about individual intervention plans that have been developed for CYPs accepted through the national moderation process. Some members of the Panel are employed directly by the Unit and others are seconded from the sectors. Their fieldwork experience and specialist knowledge cover a wide range of types of need.

Plan Adviser: a member of the HCN Unit staff who is able to work closely with the IST in preparing the CYP's application and developing the intervention plan.

Quarterly Review: a formal review of the progress made by the CYP in the previous three months. It is an opportunity for the members of the intersectoral team (including family/whānau) to report on gains that have resulted from the interventions detailed in the plan. It is also a time to set new objectives and amend the strategies for achieving them.

Sectors: the three government sectors that worked together to establish the HCN Unit are the Ministries of Health and Education and the Department of Child, Youth and Family Services. In practice, for CYPs to be eligible for ISIP funding, they must have the active engagement of the service delivery arms of at least two of the sectors, eg: Group Special Education (GSE), Ongoing and Reviewable Resourcing Scheme (ORRS) fundholder schools, Child and Adolescent Mental Health Service (CAMHS) teams, Disability Support Services, or care and protection and/or youth services through Child Youth and Family.

Service profile: a form for recording the type and level of service that a CYP is both eligible for and has been receiving at the point when application to HCN is made.

SMART: specific, measurable, achievable, realistic and time-framed.